MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

03500

Reg. Dist. No. 8

1. PLACE OF DEATH:
County Allegany
City or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 36 yrs 6 mos 23 days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? 2

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No. 21 Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war ---

3.(a) FULL NAME Ellis Byers Abbott

3.(b) Social Security Number 217-03-5888

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Ellen Alexander
6.(c) If alive, give age: 25 years
7. Birth date of deceased (mo., day, yr.): Oct. 20, 1910
8. AGE: Years 36 Months 6 Days 23 If less than one day ... hrs. ...
9. Birthplace: Lonaconing Allegany Co. Md
(Town, county, and state)
10. Usual occupation: Carpenter Bldg
11. Industry or business: Marshall Lumber Co
FATHER
12. Name: Wm. E. Abbott
13. Birthplace: Scotland
MOTHER
14. Maiden name: Jane Gordon
15. Birthplace: Unknown
16. Informant: William Abbott
Address: Lonaconing, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 16, 1947 (month) (day) (year)
Cemetery or crematory: Cemetery-Laurel Hill
Location: Frazer, W.Va.
18. Funeral director: W. Eichhorn
Address: Lonaconing, Md.
19. 5/16 1947 (Date rec'd by registrar) Jeannette M Boor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1947, at 7:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25 1947, to May 13 1947 and that I last saw him alive on May 13 1947

Immediate cause of death	DURATION
Acute Myocardial failure	
Due to Chronic Myocarditis	2 yr.
Cardiac hypertrophy	"
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Norman Reeves, M.D. M. D. or other
Address Westernport, Md Date signed 5-14-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits: M

DR. W.F. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

Reg. Dist. No. 03501

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 289 days

Hospital, institution, or street address where death occurred: Memorial Hosp. (302 WAVERLY TERRACE)

How long in hospital or institution? 289 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

Street No.: 302 WAVERLY TERRACE (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: MRS. MINNIE ALDERTON

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife: JAMES F. ALDERTON

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): AUG. 16 1876

8. AGE: Years	Months	Days	If less than one day
70	8	15	..... hrs. ..... min.

9. Birthplace: MARYLAND (Town, county, and state)

10. Usual occupation: HOUSEWORK

11. Industry or business:

FATHER — 12. Name: JACOB THOMAS

FATHER — 13. Birthplace: GERMANY

MOTHER — 14. Maiden name: Mary Jane McTEE

MOTHER — 15. Birthplace: MARYLAND

16. Informant: Lloyd Bucy

Address: 307 Helen St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/4/47 (month) (day) (year)

Cemetery or crematory: Greenmount Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. May 3 19 47 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 1, 1947 at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-16- 1946 to 5-1- 1947 and that I last saw h[illegible] alive on 5-1- 1947

	DURATION
Immediate cause of death: Broncho-Pneumonia	
Due to: Generalized Arteria Sclerosis	2 days
Due to:	
Other conditions: Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.: None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed: 5-2-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Outside of City Limits

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03502

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Rural Cumberland,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
R. D. #3 Bedford Rd. Cumberland,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Rural Cumberland,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R. D. #3 Bedford Rd. Cumberland,
(If rurol, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: RAYMOND WILLIAM ARMBRUSTER

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Maude Elizabeth Wolford
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Apr. 6, 1881

8. AGE: Years	Months	Days	If less than one day
66	1	4	hrs. min.

9. Birthplace: Cumberland, Allegany, Md.
(Town, county, and state)
10. Usual occupation: Retired Circulation Mgr.
11. Industry or business: Cumberland daily news

FATHER
12. Name: Wm. Armbruster
13. Birthplace: Cumberland, Md.

MOTHER
14. Maiden name: Minnie Miller
15. Birthplace: Cumberland, Md.

16. Informant: Mrs. Maude Armbruster
Address: R. D. #3 Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 13, 1947 (month) (day) (year)
Cemetery or crematory: St. Lukes Cem.
Location: Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. May 13 19 47 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10, 19 47 at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 19 47, to May 10 19 47
and that I last saw h alive on 5/10/47 19

Immediate cause of death	DURATION
Myocardial failure	
Due to Left bundle branch block	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: [illegible] Date signed: 5/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

03503

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 DAYS
Hospital, institution, or street address where death occurred:
SYLVAN RETREAT
How long in hospital or institution? 10 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: FROSTBURG
(If outside city or town limits, write RURAL and give nearest town)
Street No. 235 MAPLE ST.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: WILLIAM HENRY BAKER

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: FANNY L. BAKER
6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): FEBRUARY 2, 1869

8. AGE: Years	Months	Days	If less than one day
78	3	1	....hrs. ....min.

9. Birthplace: HAWKINSTOWN, VIRGINIA
(Town, county, and state)
10. Usual occupation: CARPENTER
11. Industry or business:

FATHER
12. Name: JACOB BAKER,
13. Birthplace: VIRGINIA

MOTHER
14. Maiden name: ELIZABETH FUNK,
15. Birthplace: VIRGINIA

16. Informant: RALPH BAKER,
Address: FROSTBURG, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof MAY 6, 1947 (month) (day) (year)
Cemetery or crematory: SALISBURY
Location: SALISBURY, PA.
18. Funeral director: J. R. DURST,
Address: FROSTBURG, MD.

19. May 5, 1947 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 1947, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 25 1947 to May 4 1947 and that I last saw him alive on May 3 1947

Immediate cause of death	DURATION
Vascular cerebral accident	10 day
Due to: Generalized arteriosclerosis	6 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ....Date of....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Arthur F. Jones M.D.
M. D. or other
Address: 110 S. Centre St. Date signed: 5-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Louis Briggs

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

03504

Reg. Dist. No. 2

1. PLACE OF DEATH:
County: Allegany
City or town: near Twiggtown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Rural Twiggtown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Sarah M. Barger

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: John F. Barger
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 25, 1868

8. AGE:

Years	Months	Days	If less than one day
78	11	21	hrs. min.

9. Birthplace: Mt. Storm, W. Virginia (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business: Own home
FATHER 12. Name: Benjamin Casner
13. Birthplace: W. Va.
MOTHER 14. Maiden name: Eliza Harsh
15. Birthplace: Preston Co. W. Va.
16. Informant: Mrs. Edith Wise
Address: Rt. 4, Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 19, 1947 (month) (day) (year)
Cemetery or crematory: Barger Cemetery (private)
Location: near Twiggtown, Md.
18. Funeral director: John J. Hofer
Address: Cumberland, Md.
19. May 19, 1947 (Date rec'd by registrar) May 21, 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16, 1947, at 1:15 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 16, 1946, to May 16, 1947
and that I last saw her alive on May 12, 1947

	DURATION
Immediate cause of death: Congestive heart failure	6 months
Due to: chronic myocarditis	2 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. Wilson MD (M. D. or other)
Address: 59 Greene St. Date signed: 5-19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

Dr K Lowes

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

03505

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
200 Seymour St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 200 Seymour St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Martha Ellen Barnhart

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Joseph W. Barnhart

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 25, 1868

8. AGE: Years	Months	Days	If less than one day
79	1	21	hrs. min.

9. Birthplace: Fulton Co. Penna.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Martin True

FATHER 13. Birthplace: Penna.

MOTHER 14. Maiden name: Jane Hiles

MOTHER 15. Birthplace: Penna.

16. Informant: Mrs. James Wisenburg

Address: 200 Seymour St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 19 1947 (month) (day) (year)

Cemetery or crematory: Greenway Cem.

Location: Berkley Springs, W. Va.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. May 18, 19 47 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16, 19 47 at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/16/47 19 , to 5/16/47 19

and that I last saw h.er alive on 5/14/47 19

Immediate cause of death	DURATION
Myocardial Failure	
Due to: Chronic Myocardial	
Due to: Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. P. Franklin M.D. M. D. or other

Address: Bedford Co. Pa. Date signed: 5/17/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9.45-15M

Dr. Walters

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

03506

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:
Miner's Hospital

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Barrellsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt. 1, Hyndman, Pa.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Michael Daniel Bartgis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Martha Miller Bartgis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 29, 1856

8. AGE: Years	Months	Days	If less than one day
91	1	19	..... hrs. ..... min.

9. Birthplace: Bedford Co., Pa.
(Town, county, and state)

10. Usual occupation: Rooming house proprietor

11. Industry or business

FATHER
12. Name: Daniel Bartgis
13. Birthplace: France

MOTHER
14. Maiden name: Liza Betson
15. Birthplace: Holland

16. Informant: Mrs. Bertha Krouse

Address: Star Rt., Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 21, 1947 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hofer

Address: Cumberland, Md.

19. 5-20 1947 Mrs. Nally M Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18 1947, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9 1947, to May 18 1947, and that I last saw him alive on May 18 1947.

	DURATION
Immediate cause of death: Cerebral accident	3 wks.
Due to:	
Due to:	
Other conditions: Bronchial pneumonia	10 days

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Hilda Jane Walters M.D.
M. D. or other

Address: 1 E. Main St. Frostburg Md. Date signed: 5/20/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

03507

1454

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Weeks

Hospital, institution, or street address where death occurred:
324 Bedford St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Flintstone Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rt # 1.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Grace Bennett

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Joseph Bennett

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 25 1873

8. AGE: Years	Months	Days	If less than one day
73	4	25	..... hrs. ..... min.

9. Birthplace: Barnum Garrett Co, Maryland
(Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER
12. Name: Otho Barnard
13. Birthplace: Garrett Co, Maryland

MOTHER
14. Maiden name: Martha Lohr
15. Birthplace: Garrett Co, Maryland

16. Informant: Mrs Ross Leasure

Address: 324 Bedford St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/23/47 (month) (day) (year)

Cemetery or crematory: Fairview Cemetery

Location: Artemas, Pa.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. May 22, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 1947 at 4-35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-27-1947 to 5-20-1947 and that I last saw h... alive on 3-3-1947

	DURATION
Immediate cause of death: Complications of Arteriosclerosis	
Due to: Generalized	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wm. F. Williams M. D. or other

Address: Cumberland Date signed: 5/21/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03508 Reg. Diat. No. 10

1. PLACE OF DEATH:

County: Allegany

City or town: Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 yrs 5 mo.

Hospital, Institution or street address where death occurred: Mt. Savage, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Mt. Savage, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Leo Elsworth Bennett

3.(b) Social Security Number: 227-05-8035

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Barbara Lancaster

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Oct. 2nd. 1892

8. AGE:

Years	Months	Days	If less than one day
54	7	11	hrs. min.

9. Birthplace: Lonaconing, Allg. Md. (Town, county, and state)

10. Usual occupation: Miner

11. Industry or business: Coal Mines

FATHER — 12. Name: George W. Bennett

FATHER — 13. Birthplace: Penna.

MOTHER — 14. Maiden name: Jessie Nicholls

MOTHER — 15. Birthplace: Scotland

16. Informant: Mrs. Leo E. Bennett

Address: Mt. Savage, Md.

17. Burial, cremation, or removal. Which? Burial Date thereof: May 15-1947 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg, Md.

18. Funeral director: Jacob Walter

Address: Frostburg, Md.

19. (Date rec'd by registrar) May 13 19 47 Clemmie M. Tierney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-12 19 47, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-29 19 47, to 19 and that I last saw him alive on 4/29 19 47

Immediate cause of death	DURATION
Pulmonary tuberculosis	5 yrs
Due to: Tuberculosis of larynx	1½ mos
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank T. Harrat M.D. M. D. or other

Address: 59 E. Main St. Frostburg Date signed: 5/13/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

03509

Reg. Diat. No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Md. Savage (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs.

Hospital, institution or street address where death occurred: Md. Savage, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Allegany

City or town Md. Savage (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Caroline Laura Best

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Francis Best

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 19 - 1863

8. AGE:

Years	Months	Days	If less than one day
83	6	28	..... hrs. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Rudolph Nordmann

FATHER 13. Birthplace Germany

MOTHER 14. Maiden name Lena Knapp

MOTHER 15. Birthplace Germany

16. Informant Mrs. Frederick Miller

Address Md. Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-20-1947 (month) (day) (year)

Cemetery or crematory St. George's

Location Md. Savage, Md.

18. Funeral director Jacob Bafes

Address Ellicott City, Md.

19. May 20 1947 (Date rec'd by registrar) Veronica McDermott Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17th 1947 at 6:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9th 1947, to May 17th 1947 and that I last saw h[illegible] alive on May 17 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage.	1 week
Due to Vascular Hypertension & arteriosclerosis.	
Due to	
Other conditions Generalized arteriosclerosis.	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE William E. Mosley M. D. or other

Address Md Savage, Md Date signed 5-19-'47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61 03

C3510

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penna. County Somerset

City or town Wellersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Margaret Lucy Bittner

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Garfield O. Bittner

6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) December 13, 1888

8. AGE:

Years	Months	Days	If less than one day
58	5	7	hrs. min.

9. Birthplace Wellersburg, Somerset Co, Pa (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business ?

FATHER 12. Name Louis Blank

13. Birthplace Pennsylvania

MOTHER 14. Maiden name Mary Snyder

15. Birthplace Pennsylvania

16. Informant Wilbert L. Bittner

Address Corriganville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 24 1947 (month) (day) (year)

Cemetery or crematory Semple Cemetery

Location Meyersdale Pa R.D.

18. Funeral director Harvey T. Legler

Address Myndmar, Pa.

19. May 22, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20, 1947, at 2:00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20 1947, to May 20 1947 and that I last saw h[illegible] alive on May 20 1947

	DURATION
Immediate cause of death Pulmonary Congestion	4 hrs.
Due to Auricular Fibrillation	[illegible]
Due to	
Other conditions Diabetes Mellitus	[illegible]

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David T. Lee M.D. M. D. or other

Address 18 E. Oldtown Rd Cumberland Md Date signed May 24, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03511

Reg. Dist. No. 9

46 e

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, Institution, or street address where death occurred: 173 W. Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. Co. County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 173 W. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William McTabe Blocher

3.(b) Social Security Number: 216-07-4072

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Vassie E. Harden

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): July 22nd. 1886

8. AGE: Years: 60 | Months: 10 | Days: 9 | If less than one day: hrs. min.

9. Birthplace: Little Savage, Garrett Co. Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Kelley Springfield Co

FATHER

12. Name: Isaac Blocher

13. Birthplace: Austin, Garrett Co. Md.

MOTHER

14. Maiden name: Sophia Anderson

15. Birthplace: Frostburg, Md.

16. Informant: Harold W. Blocher

Address: 16 High St. Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 2 1947 (month) (day) (year)

Cemetery or crematory: Johnson Cemetery

Location: Rt. 40 Frostburg, Md.

18. Funeral director: Jacob Kaffer

Address: Frostburg, Md.

19. 6-2 1947 Mrs. Nancy H. Rae (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31 1947, at 2:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1942 to 5/31 1947 and that I last saw him alive on 5/29 1947

Immediate cause of death: Carcinoma of Colon (Recurrent) — DURATION: 5 yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma Rt colon

Date of op. 6/6/42

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Hilda Jourdwalt M. D.

M. D. or other

Address: Frostburg, Md. Date signed: 6/2/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

166

03512

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Rural) R.F.D. 4 North Branch Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Near Cumberland, Rural

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Rural) R.F.D. 4 North Branch Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Near Cumberland, Rural
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James Dixon Bloss

3. (b) Social Security Number 705-12-7875

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Mary Ethel Monnett

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 5, 1891

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
56	0	5		

9. Birthplace North Branch Maryland (Town, county, and state)

10. Usual occupation Blacksmith

11. Industry or business B & O Shops.

FATHER 12. Name Geo. W. Bloss

13. Birthplace Maryland

MOTHER 14. Maiden name Rachael Trumbaugh

15. Birthplace Germany

16. Informant Mrs. James D. Bloss

Address North Branch Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/13/47 (month) (day) (year)

Cemetery or crematory Davis Memorial.

Location Cumberland, Md.

18. Funeral director Louis Stein Inc.

Address 117 Frederick St. Cumb. Md.

19. May 13 19 47 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 19 47 at 10.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive Dead May 11 19 47

Immediate cause of death Pulmonary hemorrhage — DURATION: at once

Due to 22 rifle bullet through lungs

Due to shot by daughter Ethel Mae Bloss

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide homicide Date of 5-10-47

Where did injury occur? North Branch (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?) home

Means of injury as above Injured at work? no

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D. (M. D. or Coroner)

Address Cumberland Md Date signed 5-11-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

169

03513 5

Reg. Dist. No.

1. PLACE OF DEATH:

County: Allegany crossing

City or town: rural) about 1/4 mi. west of Fairgo

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 5 hours

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: rural-near Dawson Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War 2

3.(a) FULL NAME: Francis James Bobo

3.(b) Social Security Number: 233-34-5949

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): July 7- 1915

8. AGE: Years	Months	Days	If less than one day
31	9	28	... hrs. ... min.

9. Birthplace: Westernport, Allegany, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farm

FATHER
12. Name: James M. Bobo
13. Birthplace: Dawson, Md.

MOTHER
14. Maiden name: Lulu M. Robinette
15. Birthplace: Clarysville, Md

16. Informant: Mrs. Lulu M. Williams

Address: Rt. 2 Keyser, W.Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 7 1947 (month) (day) (year)

Cemetery or crematory: Dawson Methodist Cemetery

Location: Dawson, Md.

18. Funeral director: John A. Hafer

Address: Cumberland Md

19. May 7 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5 1947, at about 3.45 A.M. E.T.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw him alive on Dead May 5 1947

Immediate cause of death	DURATION
Crushed skull, decapitation & Exsanguination	at once
Due to trespasser on B&O.R.Ry property & wheels of train	
Due to servered head	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 5-5-47

Where did injury occur? B&O.R.Ry near Fairgo (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?) as above

Means of injury: run over by train Injured at work? no

Deputy Medical Examiner - Allegany Co

23. SIGNATURE: H.V. Deming M.D. H.V. Deming M.D. M. D. or other

Address: Cumberland Md Date signed: 5-6-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Outside of City Limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

02514

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Lavale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 yrs
Hospital, Institution, or street address where death occurred: Near Cumberland, Rural
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Lavale
(If outside city or town limits, write RURAL and give nearest town)
Street No. Near Cumberland, Rural
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Nicholas N. Bolvin

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Laura Hill Bolvin
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 12, 1863

8. AGE: Years 84 | Months 1 | Days 15 | If less than one day ..... hrs. ..... min.

9. Birthplace Carltown, Pa.
(Town, county, and state)

10. Usual occupation Retired Lumberman

11. Industry or business

FATHER
12. Name Joseph Bolvin
13. Birthplace Penna

MOTHER
14. Maiden name Elizabeth Westover
15. Birthplace Penna

16. Informant Earl Combs
Address LaVale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 31, 1947 (month) (day) (year)

Cemetery or crematory XXXXX Hillcrest
Location Cumberland, Md.

18. Funeral director Harvey H. Zeigler
Address Hyndman, Pa.

19. May 30, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/27/47 19..... at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 16, 1947 to 5/27 19 47 and that I last saw h... alive on 5/20 19 47

Immediate cause of death	DURATION
Cancer of Rectum	
Stricture	
Due to Arteriosclerotic Heart disease	
Due to	
Other conditions Old age	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Elizabeth Briggs M.D. M. D. or other
Address Lonaconing, Md. Date signed 5/30/47

Within corporate limits

Whitworth

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03515

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 236 N. Mechanic St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Kenneth M. Burkett

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 14, 1947

8. AGE: Years	Months	Days	If less than one day
0	4	9	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany, Maryland
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER
12. Name: Ray Burkett
13. Birthplace: Hyndman, Pa

MOTHER
14. Maiden name: Evelyn Ross
15. Birthplace: Mineral Co., W. Va.

16. Informant: Ray Burkett
Address: Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 25, 1947 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hofer

Address: Cumberland, Md.

19. May 25, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23 1947, at 5:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 May 1947, to 23 May 1947 and that I last saw h.. alive on 23 May 1947

Immediate cause of death	DURATION
Pneumonia, Lobar	
Bulbar	
Due to: Uremia	
Due to:	
Other conditions: Strabismus, operation March	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Fuller B. Muckwood M. D. or other

Address: 112 Bedford St. Date signed: 24 May 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03516

50

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 days

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Ocean, Maryland (If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Mrs. Laura Elise Buskirk (Buskirk)

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Wm. H. Buskirk

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Jan 1, 1873

8. AGE: Years 74 | Months 4 | Days 28 | If less than one day: hrs. min.

9. Birthplace: (Miller) - Near Midland Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own home

FATHER — 12. Name: Elise

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: James Denver Buskirk

Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 31, 1947 (month) (day) (year)

Cemetery or crematory: Buskirk Burying Ground

Location: Davis Mt. Near Midland

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md

19. 5-30 1947 (Date rec'd by registrar) Mrs. Nadey N. Rae Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 1947, at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14. 1947, to May 29 1947 and that I last saw her alive on May 28. 1947

Immediate cause of death	DURATION
Chr Nephritis	2 yrs
Due to	
Due to	
Other conditions: Carcinoma Rt Breast	6 mos

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. O. McLaughlin M.D. M. D. or other

Address: Frostburg Md. Date signed: 5-29-47

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Outside of City Limits

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 164a

CERTIFICATE OF DEATH

03517 4
Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

I

1. PLACE OF DEATH:
County Allegany
City or town (Rural) Spring Gap Md (Colliers Run)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town (Rural) Spring Gap Md (Colliers Run)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Cora A. Catlett

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	divorced

6.(b) Name of husband or wife: Cecil Roy Catlett
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Jan. 23 1884

8. AGE: Years	Months	Days	If less than one day
63	3	9	... hrs. ... min.

9. Birthplace: Williamsport Md. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: At Home
FATHER 12. Name: James Wolz
13. Birthplace: Maryland
MOTHER 14. Maiden name: Martha Dodd
15. Birthplace: Maryland
16. Informant: Cecil R. Catlett
Address: Spring Gap Md.
17. Burial, cremation, or removal. Which?: Burial — Date thereof: 5/5/47 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Fayette St. Cumb. Md.
18. Funeral director: Louis Stein Inc.
Address: Cumberland Md.
19. (Date rec'd by registrar): May 5 1947 — J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2 1947, at about 8 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw her alive on Dead May 2 1947

Immediate cause of death	DURATION
Strangulation	at once
Due to: Despondency	about 1 yr.
Due to: nervousness	several years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide — Date of: 5-2-1947
Where did injury occur? Rural (City or town) Spring Gap, (County) Alleg. Co. (State) Md.
Injured at home, farm, industry, public place (where?): Home
Means of injury: Strangulation by strip of muslin placed around neck — Injured at work? No

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D. (M. D. or other)
Address: Cumberland Md. Date signed: 5-2-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03518

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany Co.
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since 1911
Hospital, Institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 303 Virginia Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Luigi Cifala

3.(b) Social Security Number: 214-05-8725

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Catherine Cifala
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): June 21, 1877

8. AGE: Years	Months	Days	If less than one day
69	11	0	____ hrs. ____ min.

9. Birthplace: Italy (Town, county, and state)
10. Usual occupation: Pres - Cumberland Motor Express Co.
11. Industry or business: Own.

FATHER
12. Name: Basilo Cifala
13. Birthplace: Italy

MOTHER
14. Maiden name: — Stefano
15. Birthplace: Italy

16. Informant: Catherine Cifala
Address: 303 Virginia Ave. Cumberland Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: May 23, 1947 (month) (day) (year)
Cemetery or crematory: St Peters + Pauls Cemetery
Location: Cumberland, Md

18. Funeral director: Louis Stein Sons
Address: Cumberland, Md.

19. (Date rec'd by registrar) May 23, 1947 J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21, 1947 at 2:42 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4, 1947, to May 21, 1947 and that I last saw him alive on May 20, 1947

Immediate cause of death	DURATION
Pulmonary embolism	Few minutes
Due to:	
Due to:	
Other conditions: Chronic myocarditis	1 year

(Include pregnancy within 3 months of death)

Major findings of operations: Cystotomy for urinary retention
Cut urethra very tight - dilated post mortem. Date of op. May 12-47
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. F. Swaskis Jr. M.D. M. D. or other
Address: Cumberland, Md. Date signed: 5/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03519

CERTIFICATE OF DEATH

Reg. Dist. No. 6

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Allegany
City or town: Barton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Mo
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Barton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Robert Floyd Clark

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: —
6.(c) If alive, give age —— years
7. Birth date of deceased (mo., day, yr.): Jan 21, 1947
8. AGE: Years —; Months 4; Days 1; If less than one day ... hrs. ... min.
9. Birthplace: Lonaconing Allegany Md (Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name: Floyd Clark
13. Birthplace: Barton, Md.

MOTHER
14. Maiden name: Helen E. James
15. Birthplace: ~~[illegible]~~ Johnstown, Pa

16. Informant: Floyd C. Clark
Address: Barton Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof: May 23 1947 (month) (day) (year)
Cemetery or crematory: Laurel Hill
Location: Moscow Md
18. Funeral director: Ellsworth S. Kyle
Address: Westernport Md

19. May 23 1947 (Date rec'd by registrar) [illegible] Baker Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1947, at 5:40 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 21 1947, to May 22 1947 and that I last saw him alive on May 22 1947

	DURATION
Immediate cause of death: convulsions with history of scarlet fever about May 1st 47	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Henry M. Hodgson M.D. (M. D. or other)
Address: Lonaconing, Md. Date signed May 22 47.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Paul R. Wilson
Piedmont, W. Va.

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 years

Hospital, Institution, or street address where death occurred:
442 Spruce Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 442 Spruce Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: EMMA JANE CLEM

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Jacob Clem

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 30, 1876

8. AGE: Years	Months	Days	If less than one day
71	0	0	____ hrs. ____ min.

9. Birthplace: Powells Fort, Shenandoah, Va.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: own home

FATHER
12. Name: Joel Rittenour

13. Birthplace: Penna

MOTHER
14. Maiden name: Martha Shuff

15. Birthplace: Virginia

16. Informant

Address

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: June 2, 1947
(month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Maryland

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Maryland

19. June 2 1947 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 1947, at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2 1947, to May 30 1947

and that I last saw her alive on May 30 1947

Immediate cause of death	DURATION
Acute Edema of Lungs	1 Day
Due to: Hemiplegia and other paralysis of unspecified origin	3 Months
Due to: Hypertension	5 Years
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Paul R. Wilson M.D.
M. D. or other

Address: Piedmont, W. Va. Date signed: June 2, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

Evidence for the chan e of surname of deceased is shown on 93d

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. G 11 JUN 18 1947

CERTIFICATE OF DEATH

Reg. Diat. No. 03521

1. PLACE OF DEATH:

County Allegany

City or town 207 Bedford St. Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs (?)

Hospital, Institution, or street address where death occurred:
207 Bedford St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 207 Bedford St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME George Andrew James A. Cline

3. (b) Social Security Number 705-07-6703

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Helen Winefield Cline

6.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) March 30. 1887

8. AGE: Years	Months	Days	If less than one day
60	1	14	hrs. min.

9. Birthplace Ridgeley, Mineral Co. W. Va.
(Town, county, and state)

10. Usual occupation B&O.R.Ry trackman

11. Industry or business B & O RR

FATHER 12. Name James Cline

13. Birthplace Virginia

MOTHER 14. Maiden name Ella Miller

15. Birthplace Maryland

16. Informant Wife Helen W. Cline

Address 207 Bedford St. Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 17, 1947 (month) (day) (year)

Cemetery or crematory St Peter & Paul's Cemetery

Location Cumberland, Maryland

18. Funeral director Louis Stein, Inc.

Address Cumberland Maryland.

19. May 16, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1947 at 10.15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive on Dead May 14 1947

Immediate cause of death	DURATION
Myocarditis	several years
Due to	
Due to	
Other conditions Bronchial Asthma	about 3 months

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H. V. Deming M.D. H. V. Deming MD M. D. or other

Address Cumberland Md Date signed 5-17-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 6-45-15M

Within corporate limits — Dr. Tolson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 122a

CERTIFICATE OF DEATH

03522

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 505 Green Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Carl Coleman

3. (b) Social Security Number: 226-10-0025

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored [redacted]	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 14, 1908

8. AGE: Years	Months	Days	If less than one day
38	7	11	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Shoe repairman
11. Industry or business

FATHER
12. Name: George W. Coleman
13. Birthplace: Maryland

MOTHER
14. Maiden name: Laura V. Lance
15. Birthplace: Maryland

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/28/47 (month) (day) (year)
Cemetery or crematory: Summer Cem.
Location: Cumberland Md.

18. Funeral director: Lewis Stein Inc.
Address: Cumberland Md.

19. May 27 19 47 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25, 19 47 at 11:50 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 5-19- 19 47 to 5-25- 19 47 and that I last saw him alive on 5-24-47 19

Immediate cause of death	DURATION
Strangulated inguinal hernia with peritonitis	1 year about 6 days.
Due to	
Due to	
Other conditions: Purulent epididymo-orchitis	

(Include pregnancy within 3 months of death)

Major findings of operations: no operation Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Howard L. Tolson M.D. M. D. or other
Address: Cumberland Md. Date signed 5-26-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03523 / 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs
Hospital, institution, or street address where death occurred:
300 Park St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 300 Park St.
(If rural, give LOCATION)
2.(a) If veteran, name war 1st World War

3.(a) FULL NAME Joseph Bernard Coniff

3.(b) Social Security Number 705-05-4376

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Ruth Hart
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 12, 1895

8. AGE: Years	Months	Days	If less than one day
51 ~~52~~	9	27	..... hrs. ..... min.

9. Birthplace Keyser W. Va.
(Town, county, and state)
10. Usual occupation Clerk
11. Industry or business B & O Ry.
FATHER 12. Name James Coniff
13. Birthplace Ireland.
MOTHER 14. Maiden name Mary Houghton
15. Birthplace W. Va.
16. Informant Frances Elma Coniff
Address Cumberland
17. Burial (Burial, cremation, or removal? Which?) Date thereof May 12 47 (month) (day) (year)
Cemetery or crematory St. Mary's
Location Oldtown Rd. Cumberland.
18. Funeral director Louis Stein Sons
Address Cumberland
19. May 12 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1947, at 7:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 to May 9 1947 and that I last saw h alive on May 1 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. P. Franklin Jr. M.D.
M. D. or other
Address Cumberland Md. Date signed 5-12-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 03524 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Brunswick Hotel Baltimore St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME (Joseph) Gieuseppi Deroma Cossu

3.(b) Social Security Number 220-10-7023

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 20, 1877

8. AGE: Years	Months	Days	If less than one day
69	7	4	hrs. min.

9. Birthplace: Italy
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Contracting Co.

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: (Papers On Person) By C.L. George
Address: 202 Greene St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 27, 1947 (month) (day) (year)

Cemetery or crematory: S.S. Peter & Paul

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. May 26 19 47 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24, 1947 at 6:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 15 1947 to May 24 1947 and that I last saw him alive on May 23 1947

Immediate cause of death	DURATION
Cancer of spine and pelvic bones.	1 year
Due to: Could not find site of	
Due to: original growth	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: P. V. Trenaskis Jr. M.D. M. D. or other

Address: Cumberland, Md. Date signed: 5/26/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 f Dr Paul R. Wilson 035 25

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Luke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, Institution, or street address where death occurred: Division Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3 miles East of Lonaconing

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: MARY ANN CRAWFORD

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George Crawford

6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): September 6, 1883

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
63	8	1		

9. Birthplace: Barton, Allegany, Maryland (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Own home

FATHER

12. Name: John E. Klipstein

13. Birthplace: Unknown

MOTHER

14. Maiden name: Mary E. Myers

15. Birthplace: Barton, Maryland

16. Informant: Mrs Mary Groves

Address: Luke, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 11, 1947 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Md

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Maryland

19. May 10 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7 19 47 at 9:05 p.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Apr. 27 19 47 to May 7 19 47 and that I last saw her alive on May 7 19 47

Immediate cause of death	DURATION
Carcinoma of liver with general Metastasis	3 Months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of liver Date of op. May 5, 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Paul R Wilson M.D. M. D. or other

Address: Piedmont W. Va Date signed: May 9, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

03526 9

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
45 N. Water St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 45 N. Water
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles Samuel Darrow

3.(b) Social Security Number: 220-07-6644A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Bessie E. Darrow

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 8-1866

8. AGE: Years	Months	Days	If less than one day
81	1	17	hrs. min.

9. Birthplace: Cumberland-Alleg-Md.
(Town, county, and state)

10. Usual occupation: Coal inspector

11. Industry or business

FATHER
12. Name: Wm. Darrow
13. Birthplace: Boston, Mass

MOTHER
14. Maiden name: Mary E. Brody
15. Birthplace: Frankford, Wva

16. Informant: James A. Darrow
Address: Frostburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 28-1947 (month) (day) (year)

Cemetery or ~~cemetery~~: Rose Hill

Location: Cumberland, Md.

18. Funeral director: J. J. Dusy

Address: Frostburg, Md

19. 5-27 (Date rec'd by registrar) 1947 Mrs Nancy H. Rae Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23 1947 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 19 to May 23 1947 and that I last saw h alive on May 23 1947

Immediate cause of death	DURATION
May 1	
Chronic Myocarditis	Several years
Due to: Arteriosclerosis	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. O. Lane M.D.
M. D. or other

Address: Frostburg Md. Date signed: 5-26-47

White corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03527

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 Years

Hospital, institution, or street address where death occurred:

Sylvan Retreat

How long in hospital or institution? 12 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 512 Hill St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

George S. Douglas

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Anna Douglas

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 31 1868

8. AGE: Years	Months	Days	If less than one day
78	9	21	..... hrs. ..... min.

9. Birthplace: Staunton, Virginia (Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business: "

FATHER

12. Name: Unknown

13. Birthplace: "

MOTHER

14. Maiden name: "

15. Birthplace: "

16. Informant: Anna Flowers

Address: 523 Washington St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/24/47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. May 24 1947 (Date rec'd by registrar) J. C. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22 1947, at 5 A.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 2 1947, to May 22 1947

and that I last saw him alive on May 17 1947

Immediate cause of death	DURATION
Acute myocardial failure	5 min
Due to Luetic cardio-vascular disease	3 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Arthur F. Douglas M. D. M. D. or other

Address: 110 S. Center St. Date signed: 5-23-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

03528

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct address is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 19 Harrison St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Clara Belle Dremming

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 13 1879

8. AGE: Years 67 Months Days If less than one day ..... hrs. ..... min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business At Home

FATHER
12. Name William E. Dremming
13. Birthplace Pennsylvania

MOTHER
14. Maiden name Evelyn F. Jackson
15. Birthplace Virginia

16. Informant Miss Alma Wilson
Address 908 Md. Ave., City

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 8 1947 (month) (day) (year)
Cemetery or crematory Rose Hill Cem.
Location Cumberland, Md.

18. Funeral director Louis Stein Inc.
Address Cumberland, Md.

19. May 8 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1947, at 12-31 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 27 May, 1946 to 7 May 1947 and that I last saw her alive on May 7, 1947

Immediate cause of death	DURATION
Hypertensive heart disease	?
Terminal cardiac failure	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Alfred Vance M. D. or other
Address 110 S. Centre St. Date signed 7 May, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 169

CERTIFICATE OF DEATH

03529

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany Md.

City or town about 1/4 mi. east of Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Almost two years

Hospital, institution, or street address, where death occurred:

State Street

How long in hospital or institution? 1

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Rural) Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

Street No. State Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Martha Elizabeth Duckworth

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife Henry A Duckworth

6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) July 30 - 1872

8. AGE: Years	Months	Days	If less than one day
74	9	1	hrs. min.

9. Birthplace Phoenix Hill Near Hesterpoint Md (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own home

FATHER 12. Name Hezzy Shriver

13. Birthplace Phoenix Hill near Barton Md

MOTHER 14. Maiden name Sara Warwick

15. Birthplace Garrett Co. Near Barton

16. Informant Miss Columbus Ryan

Address State Street, Lonaconing, Md

17. Burial Date thereof May 3, 1947 (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory Oak Hill Cemetery

Location Lonaconing, Md.

18. Funeral director C. M. Eichhorn

Address Lonaconing, Md

19. 5-3 1947 Janette M Boal

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1947 at 3.25P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw her alive on Dead May 1 1947

Immediate cause of death Decapitation & Exsanguination

DURATION: at once

Due to Accident, struck & ran over by a W.Md R.Ry coal train backing up.

Due to .....

Other conditions Upper part of chest crushed & compound comminuted fracture of right arm

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 5-1-47

Where did injury occur? near Lonaconing Allegany Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) on W.Md.R.Ry tracks.

Means of injury Run over by coal train Injured at work no

Deputy Medical Examiner - Allegany

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.

M. D. or other

Address Cumberland, Md Date signed 5-1-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

03530

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs (?)

Hospital, institution, or street address where death occurred:
414 Grand Ave.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 414 Grand Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: John T. Dulin

3. (b) Social Security Number: 218-24-8240

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: none

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 2- 1878

8. AGE: Years	Months	Days	If less than one day
68	9	10	____ hrs. ____ min.

9. Birthplace: Kayser, Mineral Co. West Va.
(Town, county, and state)

10. Usual occupation: Retired Brakeman

11. Industry or business: B & O. R.R.

FATHER
12. Name: Gabriel Dulin
13. Birthplace: West Va.

MOTHER
14. Maiden name: Unknown
15. Birthplace:

16. Informant: Charles T. Dulin
Address: 414 Grand Ave Cumberland. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 17, 1947 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.

Address: Cumberland. Md.

19. May 16 19 47 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 19 47 at about 7.30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ____ 19____, to ____ 19____

and that I last saw him alive on May 13 19 47

Immediate cause of death	DURATION
Coronary occlusion	at once
Due to: arteriosclerosis	
Due to:	
Other conditions: ***** Had been dead about 20 hours when found. (Include pregnancy within 3 months of death)	

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D.
M. D. or other

Address: Cumberland Md Date signed: 5-13-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

03531

CERTIFICATE OF DEATH

Reg. Diat. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 years

Hospital, Institution, or street address where death occurred: State Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

Street No.: State Street (If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Mary Ann Gay Elkins

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Joseph Elkins

6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): April 6, 1877

8. AGE: Years: 70 | Months: | Days: | If less than one day: ... hrs. ... min.

9. Birthplace: Pearre, Washington Co., Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: None

FATHER — 12. Name: John Gay

FATHER — 13. Birthplace: Great Cacapon

MOTHER — 14. Maiden name: Sara Dawson

MOTHER — 15. Birthplace: Great Cacapon

16. Informant: Mrs. J. H. Elkins

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 3 1947 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: M. Eichhorn

Address: Frostburg, Md.

19. 6/3 1947 (Date rec'd by registrar) Jaclutte M. Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 1947, at 10 00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1944, to May 30 1947 and that I last saw h.. alive on May 29 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	5 days
Due to: Hypertensive heart disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Hilda Laurel Walters M.D. M. D. or other

Address: Frostburg Md Date signed: 6/3/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

37c
CB

03532

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Penna. County:
City or town: Meyersdale Route 3
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Marvin Wayne Finzel

3.(b) Social Security Number: none

4. Sex: male
5. Color or race: white
6.(a) Single, married, widowed, or divorced: single
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): September 22 1945
8. AGE: Years: 1 Months: 7 Days: 14 If less than one day: hrs. min.
9. Birthplace: Frostburg Allegany Cty., Md.
(Town, county, and state)
10. Usual occupation: infant
11. Industry or business:
FATHER 12. Name: Stanley Finzel
13. Birthplace: Pennsylvania
MOTHER 14. Maiden name: Violet Morozek
15. Birthplace: Pennsylvania
16. Informant: Mrs. Stanley Finzel
Address: Meyersdale Pa.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 10 1947 (month) (day) (year)
Cemetery or crematory: Finzel Cemetery
Location: Finzel Md.
18. Funeral director: J.R. Durst
Address: Frostburg Md.
19. 5-10- 1947 (Date rec'd by registrar) Miss Nancy N. Poe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7 1947 at 10 00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 25 1947 to May 7 1947 and that I last saw him alive on May 7 1947

	DURATION
Immediate cause of death: Streptococcus Meningitis	8 Day
Due to: Otitis Media	13 Day
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M.D. McLine Jr. M.D. M. D. or other
Address: Frostburg Md. Date signed May 9 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

74a

CERTIFICATE OF DEATH

03534 4

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 hrs. 25 min.

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 5 hrs. 25 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town LONACONING
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME FOOR, STEPHEN PAUL

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	INFANT

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 25, 1947

8. AGE: Years	Months	Days	If less than one day
	1	13	hrs. min.

9. Birthplace MARYLAND Lonaconing, Allegany
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name CLYDE H. FOOR

13. Birthplace OHIO, Akron

MOTHER 14. Maiden name LAURA WILLIAMSON

15. Birthplace MARYLAND Barton

16. Informant Memorial Hosp.

Address Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 10 1947 (month) (day) (year)

Cemetery or crematory Forest Hill Cem

Location Moscow Md.

18. Funeral director Mr. Eichhorn

Address Lonaconing Md.

19. May 10 1947 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1947, at 8:25 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 5-7-47 1947, to 5-7-47 1947

and that I last saw him alive on 5-7-47 1947

Immediate cause of death Lymphoid Leukemia — DURATION 5 wk.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results - Lymphoid Leukemia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. W. Emerson M.D. M. D. or other

Address 126 Union St Cumberland Md. Date signed 5/8/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

03537

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 717 Bedford St.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME HOWARD W. GLISAN

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Nellie G. Fogle
Deceased 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 2, 1878

8. AGE: Years	Months	Days	If less than one day
69	0	15	..... hrs. ..... min.

9. Birthplace Cumberland, Allegany Maryland
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business Automobile Dealer

FATHER
12. Name Wm. Ross Glisan
13. Birthplace Cumberland, Md.

MOTHER
14. Maiden name Harriet Harper
15. Birthplace Elkins, W. Va.

16. Informant Mrs. Morgan C. Harris
Address 302 Schley St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 20, 1947 (month) (day) (year)
Cemetery or crematory Rose Hill Cem.
Location Cumberland, Md.
18. Funeral director Charles L. George
Address Cumberland, Md.

19. May 19, 19 47 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17, 19 47 at 3:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 16 19 46, to May 17 19 47
and that I last saw h.im alive on May 17 19 47

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to Arterio-Sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE L. B. Meekins M.D. M.D. or other
Address 49 Greene St Date signed 5-19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

Dr. Zimmerman

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 03535

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Rural (Cumberland)

(If outside city or town limits, write RURAL and give nearest town)

Street No. Narrows Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Frank J. Grabenstein

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Anna M. Grabenstein

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 19, 1863

8. AGE: Years	Months	Days	If less than one day
83	4	26	..... hrs. ..... min.

9. Birthplace Cumberland, Maryland

(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER 12. Name Justus Grabenstein

13. Birthplace Germany

MOTHER 14. Maiden name Margaret Mundy

15. Birthplace Germany

16. Informant Mrs. Joseph Coleman

Address 208 Fayette St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 19, 1947 (month) (day) (year)

Cemetery or crematory St. Peter & Paul Cemetery

Location Cumberland, Md.

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. May 19 1947 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15, 1947, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-5-47 1947, to 5-15-47 1947

and that I last saw h. alive on 5-15-47 1947

Immediate cause of death	DURATION
Myocarditis	2 yrs.
Due to —	
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. C. Zimmerman M.D. M. D. or other

Address 5-17-47 Date signed 5-17-47

10 & 2. adm 52.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 121

CERTIFICATE OF DEATH

03536

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: 220 Grand Avenue
(If outside city or town limits, write RURAL and give nearest town)

Street No. Cumberland, Maryland
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Elkana Leslie Grapes

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Polly Smith Grapes

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): August 22, 1877

8. AGE: Years	Months	Days	If less than one day
69	9	2	____ hrs. ____ min.

9. Birthplace: Moorefield, Hardy W. Va.
(Town, county, and state)

10. Usual occupation: Farmer (Retired)

11. Industry or business: Own Farm

FATHER
12. Name: Newton Grapes
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Jane Shrout
15. Birthplace: West Virginia

16. Informant: Mrs. Pearl Heavener
Address: 220 Grand Avenue, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 27 1947 (month) (day) (year)

Cemetery or crematory: Mt. Hope Christian Cemetery

Location: Near Artemus Pennsylvania

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. May 27 1947 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24 1947, at 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1947, to May 1947

and that I last saw h[illegible] alive on ____ 19____

Immediate cause of death	DURATION
(a) Hypertensive Adrenal	1 month
Due to: —	
Due to:	
Other conditions: Hypertensive Adrenal Disease	3 years

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: B. M. Schmeltzer M. D. or other

Address: 41 Grant Date signed: May 25/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Schwabe

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03538

Reg. Diat. No. .....

1. PLACE OF DEATH:

County Allegany

City or town Rural) near Rawlings Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 ½ yrs.

Hospital, institution, or street address where death occurred:

–

How long in hospital or institution? –

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Rural) near Rawlings Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. –

(If rural, give LOCATION)

2.(a) If veteran, name war –

3.(a) FULL NAME Mason Gene Groggs

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

B.(b) Name of husband or wife none

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 14 1943

8. AGE: Years	Months	Days	If less than one day
3	5	14	..... hrs. ..... min.

9. Birthplace Cumberland, Maryland

(Town, county, and state)

10. Usual occupation none

11. Industry or business –

FATHER

12. Name Burley M. Groggs

13. Birthplace Md.

MOTHER

14. Maiden name Beulah Bell Miller

15. Birthplace Md.

16. Informant Burley M. Groggs

Address Rawlings Md.

17. buried (Burial, cremation, or removal. Which?) Date thereof May 30 1947 (month) (day) (year)

Cemetery or crematory Brier Cemetery

Location Rawlings Md.

18. Funeral director Lewis & Lewis, Inc.

Address Cumberland Md. H. V. Deming

19. 6/3/47 19 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 19 47 at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....

and that I last saw him alive May 28 19 47

Immediate cause of death	DURATION
Catarrhal Pneumonia	About 3 days
Due to Measles	4 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Deputy Medical Examiner – Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M. D. or other

Address Cumberland, Md. Date signed 5-28-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82

CERTIFICATE OF DEATH

03539

Reg. Dist. No. 4

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:
Rt. 2, Flintstone

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt. 2, Flintstone, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles Oscar Hebner

3.(b) Social Security Number: 220-10-7925

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Lola Blanche Hebner

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): December 5, 1895

8. AGE: Years	Months	Days	If less than one day
51	5	25	...hrs. ...min.

9. Birthplace: Buck Valley, Pa.
(Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business: Cumb. Cement + Supply Co.

FATHER
12. Name: John Hebner
13. Birthplace: Buck Valley, Pa.

MOTHER
14. Maiden name: Laura Hill
15. Birthplace: Pa.

16. Informant: Mrs. Lola Blanche Hebner
Address: Rt. 2, Flintstone, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 1, 1947 (month) (day) (year)

Cemetery or crematory: Hillcrest

Location: Cumberland, Md

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. May 31, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 1947, at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27 1947, to May 30 1947 and that I last saw him alive on May 30 1947

Immediate cause of death	DURATION
Amyotropic Lateral Sclerosis	
Due to	
Due to	
Other conditions: Respiratory Paralysis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Benedict Skutarelic M.D.
M. D. or other

Address: Route #2 Cumberland Md Date signed: 5/30/47

Mc Lane

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 469

CERTIFICATE OF DEATH

03540

Reg. Dist. No. 9

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, institution, or street address where death occurred: 113 Mc Cullough St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 113 Mc Cullough St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Sarah A. Reisman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Harvey Reisman
6.(c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) Apr. 17th, 1872

8. AGE: Years 75 | Months 9 | Days 8 | If less than one day hrs. min.

9. Birthplace Frostburg, Alleg. Md.
(Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

FATHER 12. Name Wm. Noel
13. Birthplace Wilmington, Del.

MOTHER 14. Maiden name Sarah Shaffer
15. Birthplace Pa.

16. Informant Mrs. Victor Richards
Address R.D. No. 1 Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 28-1947 (month) (day) (year)
Cemetery or crematory Allegany Cemetery
Location Frostburg, Md.

18. Funeral director Talbert & Wade
Address Frostburg, Md.

19. 5-26 1947 Mrs. Harry N. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1947, at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 1 1947, to May 25 1947
and that I last saw her alive on May 24 1947

	DURATION
Immediate cause of death	
Carcinoma of Liver	3
Due to	
Probably originating	5
Due to	
and Pancreas	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. O. M. Lane M.D.
M. D. or other
Address Frostburg Md. Date signed 5-26-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03541

Reg. Dist. No. 4

DR FAW

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 DAYS
Hospital, Institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution? 6 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State WEST VA. County Hardy
City or town OLD FIELDS (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME SAMUED, HEISHMAN

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife IDA HEISHMAN
6.(c) If alive, give age 70 years
7. Birth date of deceased (mo., day, yr.) December 15, 1872

8. AGE: Years 74 Months 5 Days 16 If less than one day ..... hrs. ..... min.

9. Birthplace OLD FIELDS, Hardy, W. VA. (Town, county, and state)
10. Usual occupation FARMER
11. Industry or business
FATHER 12. Name HEISHMAN, JACOB
13. Birthplace W. VA
MOTHER 14. Maiden name OTILIA CRAWFORD
15. Birthplace W. VA
16. Informant Memorial Hospital
Address Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 3 1947 (month) (day) (year)
Cemetery or crematory Odd Fellows
Location Moorefield, W. Va.
18. Funeral director P. E. Grush and Son
Address Moorefield, W. Va.
19. May 31, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1947, at 11 o'clock P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 1947, to May 31 1947
and that I last saw him alive on May 31 1947

	DURATION
Immediate cause of death: Perforated duodenal ulcer	3 weeks
Due to: acute peritonitis, and	
bilious obstruction	
Due to:	
Other conditions: Senility	

(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.
Autopsy results: Perforated duodenal ulcer - acute peritonitis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wyle M Faw, Jr. M. D. or other
Address 5 Washington St. Cumb. Md. Date signed May 31, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

COTTER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94 a 23

CERTIFICATE OF DEATH

03542

Reg. Diat. No. 7

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State PENNSYLVANIA County FAYETTE
City or town PERRYOPOLIS
(If outside city or town limits, write RURAL and give nearest town)
Street No. ROUTE # 2
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
HOLLER, GRACE E. MRS.

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife HOLLER, FROSTY O.
6.(c) If alive, give age 59 years
7. Birth date of deceased (mo., day, yr.) JAN. 1, [illegible] 1887

8. AGE: Years	Months	Days	If less than one day
60	4	3	hrs. min.

9. Birthplace PA. Buffalo Mills, Bedford Co. Pa.
(Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business
FATHER 12. Name MOWERY, JACOB
13. Birthplace PA.
MOTHER 14. Maiden name SHERMAN, MARIA
15. Birthplace PA.
16. Informant Frosty O. Holler
Address Perryopolis Rt 2. Pa.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 8, 1947 (month) (day) (year)
Cemetery or crematory Little Red Stone
Location Fayette City, Pa.
18. Funeral director Harvey L. Zepler
Address Hyndman, Pa
19. May 7 1947 J. P. Franklin, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 4, 1947 1947, at 8:55A M
21. I CERTIFY that death occurred on ths date above stated; that I attended deceased from July 1945 to May 4 1947
and that I last saw h[illegible] alive on May 4 1947

Immediate cause of death	DURATION
Coronary Thrombosis	5 minutes
Due to Coronary Artery Disease	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Edwin A. Cooper M.D.
M. D. or other
Address Hyndman Pa Date signed 5.5.47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

rate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03543

CERTIFICATE OF DEATH

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Reg. Diat. No. 4

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is especially impor

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 3 hrs.

Hospital, institution, or street address where death occurred:
W.Md.R.Ry.tracks,about 300ft west of

How long in hospital or institution? River Rd. crossing

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infante give residence of mother)

State W.Va. County Mineral

City or town Rural) Keyser W.Va.R.F.D. 1
(If outside city or town limits, write RURAL and give nearest town)

Street No. Fountain Rd.near Headsville W.Va.
(If rural, give LOCATION)

2.(a) If veteran, name war World War 2

3. (a) FULL NAME Earl Delbert Hott

3. (b) Social Security Number 232-26-3090

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Mary Trenton Hott

6.(c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr.) June 18- 1917

8. AGE: Years	Months	Days	If less than one day
29	10	20	hrs. min.

9. Birthplace Headsville W.Va.
(Town, county, and state)

10. Usual occupation Rubber Worker

11. Industry or business Kelly-Springfield Tire Co.

FATHER
12. Name Samuel Walker Hott
13. Birthplace Kirby W.Va.

MOTHER
14. Maiden name Anna Laura Wilson
15. Birthplace Norman,Missouri

16. Informant Samuel Walker Hott
Address Wiley Ford W.Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/11/47 (month) (day) (year)

Cemetery or crematory Queens Point Cemetery

Location Keyser, W. Va.

18. Funeral director N. H. Rogers

Address Keyser, W. Va.

19. May 10 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1947 at about 11.30PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive May 9 1947

Immediate cause of death	DURATION
Body bisected &	at
Exsanguination	once
Due to Accident (Trespasser)	
Due to Fell from W.Md.freight train	
and body was cut in half.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide accident Date of 5-8-47

Where did injury occur? Cumberland (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?) West of River Rd. W.Md.R.Ry.

Means of injury Fell from Freight train (no

Injured at work? Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V.Deming M.D. H.V.Deming M.D.
M. D. or other

Address Cumberland Md Date signed 5-9-47

Within corporate limits

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 188

CERTIFICATE OF DEATH

03544

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 hours

Hospital, Institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 28 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Rural) R.F.D. 2 Flintstone P.O.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Break Neck Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Harold (Hearld) (Harrol) A. Hott

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife none

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 30-1940

8. AGE: Years	Months	Days	If less than one day
6	9	5	..... hrs. ..... min.

9. Birthplace Rawlings Allegany Md.
(Town, county, and state)

10. Usual occupation schoolboy

11. Industry or business

FATHER
12. Name Henry Adam Hott
13. Birthplace Petersburg W. Va

MOTHER
14. Maiden name Lottie Hall
15. Birthplace Petersburg W. Va.

16. Informant Henry A. Hott
Address RFD #2 Flintstone Md.

17. buried (Burial, cremation, or removal. Which?) Date thereof May 8, 1947 (month) (day) (year)

Cemetery or crematory Rose Cemetery

Location Rawlings Md.

18. Funeral director Lewis & Stein, Inc.

Address Cumberland Md.

19. May 8 19 47 J. P. Franklin M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 19 47 at 10.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive on Dead May 6 19 47

Immediate cause of death: General plastic peritonitis — DURATION: about 30 Hrs.

Due to Two transverse perforations of the ilium with free fecal

Due to matter in peritoneal cavity

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 5-4-47

Where did injury occur? Rural (City or town) Home (County) Allegany (State) Md.

Injured at home, farm, industry, public place (where?) Flintstone R.F.D 2 Break Neck Road

Means of injury Kicked in abdomen by horse. Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. or other

Address Cumberland, Md. Date signed 5-6-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

W. 7 Wms

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03545

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 715 Lincoln St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Near Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. Baltimore Pike

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Alice Hulet Johnson

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Thomas T. Johnson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 14, 1862

8. AGE:

Years	Months	Days	If less than one day
84	4	29	..... hrs. ..... min.

9. Birthplace Flintstone, Allegany Co. Md. (Town, county, and state)

10. Usual occupation Housework at Home

11. Industry or business

FATHER 12. Name Jasper Ash

13. Birthplace Flintstone, Md.

MOTHER 14. Maiden name Julia Fletcher

15. Birthplace Keyser W. Va.

16. Informant Mrs. Raymond Stubble

Address 715 Lincoln St. Cumb. Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof May 15, 1947 (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland Md.

18. Funeral director John J. Hafer

Address Cumberland Md.

19. May 15, 1947 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1947 at 6:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-16-1946 to 5-13-1947

and that I last saw h.e. alive on 5-6- 1947

Immediate cause of death	DURATION
Bronchopneumonia	1 wk.
Due to Generalized Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or Other

Address Cumberland Date signed 5/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

468

03533 4

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 Years

Hospital, institution, or street address where death occurred:
15 Valley St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 15 Valley St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Edward D. Johnson

3.(b) Social Security Number: 705-05-5300

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emma Pluckett Johnson

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Unknown (1880)

8. AGE: Years	Months	Days	If less than one day
67			hrs. min.

9. Birthplace: (Town, county, and state)

10. Usual occupation: Machinest

11. Industry or business: Baltimore & Ohio Railroad

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Mrs. Emma Johnson

Address: 15 Valley St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/22/47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. May 22, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 1947, at 5-45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Mar 12 1947, to May 20 1947
and that I last saw him alive on May 19 1947

Immediate cause of death	DURATION
Carcinoma	
Due to Stomach	
Due to	
Other conditions Carcinomatosis of Upper abdominal Area	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Stomach Date of op. 3-20-47

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. F. Williams M. D. or other

Address: Cumberland Date signed 5-20-47

Within corporate limits

Evidence for change of birthdate shown on: DR. HAWKINS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46e

03546

CERTIFICATE OF DEATH

Reg. No. G 110 JUN 5 1947

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: MEMORAIL HOSPITAL

How long in hospital or institution? 7 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARLYAND County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

Street No. 953 BRADDOCK ROAD (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Merion MR. STANLEY JONES

3.(b) Social Security Number 214-07-0520

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife MARIAN BEARD

6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) NOV. 26, [illegible] 11/8/1889

8. AGE: Years 57 Months 5 Days 25 If less than one day hrs. min.

9. Birthplace NEW YORK, Holland Patent (Town, county, and state)

10. Usual occupation CHEMICAL ENGINEER

11. Industry or business KELLY TIRE CO.

FATHER 12. Name EVAN JONES

FATHER 13. Birthplace [illegible] Wales

MOTHER 14. Maiden name CAROLINE GRIFFITH

MOTHER 15. Birthplace NEW YORK, Holland Patent

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal? Which?) Date thereof May 23, 1947 (month) (day) (year)

Cemetery or crematory Riverview Cem

Location Wilmington, Delaware

18. Funeral director Charles L. George

Address Cumberland, Maryland

19. May 22, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 21 1947 at 5:35A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14, 1947 to May 21, 1947 and that I last saw him alive on May 21, 1947

DURATION

Immediate cause of death Carcinoma of Mid Colon

Due to Obstructing Pain

Due to Duodenal Ulcer

Other conditions contributing Perforated

(Include pregnancy within 3 months of death)

Major findings of operations Obstructing tumor mid Colon Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. H. Hawkins M. D. or other

Address Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

Within corporate limits Schindler

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

03547

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs

Hospital, Institution, or street address where death occurred: 211 Pennsylvania Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 211 Pennsylvania Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Florida Louise Kelley

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Joseph J Kelley

6.(c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Jan 18, 1877

8. AGE: Years	Months	Days	If less than one day
70	2	8	hrs. min.

9. Birthplace Newburg, Preston Co. W. Va. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Daniel Lewis

13. Birthplace Terra Alta W. Va.

MOTHER 14. Maiden name Susan Lewis

15. Birthplace Terra Alta W. Va.

16. Informant Joseph D. Kelley

Address 211 Pa. Ave - Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 29 1947 (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland Md

18. Funeral director John J. Hafer

Address Cumberland Md.

19. May 29, 1947 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1947, at 3:00 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1946, to May 26 1947

and that I last saw h alive on May 24 1947

Immediate cause of death

DURATION

Coronary Thrombosis — 2 mos

Due to Hypertensive C. V. Disease — 4 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. M. Schindler M.D. M. D. or other

Address 41 Greene St Date signed May 29/947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 03548

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Allegany
City or town Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 yrs
Hospital, institution, or street address where death occurred:
Mt. Savage, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No. Railroad St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Jos. King

3.(b) Social Security Number 215-01-4647

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Lena Crewe
6.(c) If alive, give age: 56 years
7. Birth date of deceased (mo., day, yr.): Aug. 25 - 1866
8. AGE: Years: 69 Months: 8 Days: 15 If less than one day: hrs. min.
9. Birthplace: Elk Garden, W. Va. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Coleman Corp.
FATHER 12. Name: Patrick King
13. Birthplace: Ireland
MOTHER 14. Maiden name: Mary Gaffney
15. Birthplace: Ireland
16. Informant: Mrs. Dalma King
Address: Mt. Savage, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 13 1947 (month) (day) (year)
Cemetery or crematory: St. Patricks
Location: R.C. Savage, Md.
18. Funeral director: Jacob L. Yaker
Address: Frostburg, Md.
19. May 12 1947 (Date rec'd by registrar) Wilmer M. Dennett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9th 1947, at 11:45 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-9 1947, to 5-9 1947
and that I last saw him alive on May 9th 1947

	DURATION
Immediate cause of death: Coronary Thrombosis -	
Due to:	
Due to:	
Other conditions: Myocarditis -	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William E. Moseley M. D. or other
Address Mt Savage Md. Date signed 5/12-1947

Within corporate limits

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

147d

03549

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 2 minutes

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? about 2 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Ellerslie
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lettie Klahre

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife Robert Klahre

6.(c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) May 27, 1914

8. AGE: Years 32 Months 11 Days 15 If less than one day ..... hrs. ..... min.

9. Birthplace Centreville Pa
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name George Conner

13. Birthplace Maryland

MOTHER 14. Maiden name Anne Dewey

15. Birthplace Maryland

16. Informant Robert Klahre

Address Ellerslie, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15, 1947 (month) (day) (year)

Cemetery Porter Cemetery

Location Hyndman Pa RD

18. Funeral director Harvey H. Zeigler

Address Hyndman Pa

19. May 14, 1947 (Date rec'd by registrar) J. P. Franklin, M.D., Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1947 at 2.10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw her alive on Dead May 12 1947

Immediate cause of death	DURATION
Pulmonary embolus	about 1 hr.
Due to Spontaneous abortion	18 hrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or other

Address Cumberland Md Date signed 5/12/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

03550

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 3 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Eckhart

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Baby Klosterman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	S

B.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 13 1947.

8. AGE:

Years	Months	Days	If less than one day
			4 hrs. ..... min.

9. Birthplace Frostburg Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name George H. Klosterman

13. Birthplace Eckhart

MOTHER

14. Maiden name Wanda M. Haines

15. Birthplace Cumberland Md

16. Informant Wanda Klosterman

Address Eckhart

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-15-47 (month) (day) (year)

Cemetery or crematory Eckhart Cemetery

Location Eckhart, Md.

18. Funeral director George Henry Klosterman

Address Eckhart, Md.

19. 5-15 1947 Mrs. Nancy N. Roe

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1947, at 8:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13 1947 to May 13 1947

and that I last saw him alive on May 13 1947

Immediate cause of death	DURATION
Prematurity	
Due to Mal Pt Birth	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. Lane Jr. M.D. M. D. or other

Address Frostburg Md Date signed 5-15-47

Within corporate limits

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

54a

CERTIFICATE OF DEATH

Reg. Dist. No. 03554

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 230 Emmett Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Thelma Grace Knowlton

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife John Knowlton

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 19, 1896

8. AGE:

Years	Months	Days	If less than one day
50	5	23	..... hrs. ..... min.

9. Birthplace Hopewell, Bedford Co. Pa (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name John W. Richardson

13. Birthplace Somerset Co. Pa

MOTHER

14. Maiden name Sarah Williams

15. Birthplace Pa.

16. Informant John W. Knowlton

Address 230 Emmett Ave Cumb Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15, 1947 (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland Md

18. Funeral director John J. Hafer

Address Cumberland Md

19. May 15, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 19 47 at 1:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-24-47 19 47, to 5-12-47 19 47

and that I last saw h.... alive on 5-12-47 19 47

Immediate cause of death	DURATION
Brain Tumor (glioma)	2 mos.
Due to	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. None

Autopsy results See summary sheet

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 5/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

03552

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Eckhart Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life time

Hospital, Institution, or street address where death occurred:
R F D #1 Frostburg Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Eckhart
(If outside city or town limits, write RURAL and give nearest town)

Street No. R F D #1 Frostburg Md
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ida May Lafferty

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife John Lafferty

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 21, 1883

8. AGE:

Years	Months	Days	If less than one day
64	2	1	..... hrs. ..... min.

9. Birthplace Eckhart Allegany Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name John Dudley

13. Birthplace Eckhart Md.

14. Maiden name Elizabeth Starchler

15. Birthplace Germany

16. Informant Mrs. Donald Jeffries

Address Broadway Frostburg Md.

17. Buried Date thereof 5-25-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Eckhart cemetery

Location Eckhart Md.

18. Funeral director Jacob Trapp

Address Frostburg, Md.

19. 5-24 1947 Mrs. Daisy N. Rae
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1947, at 4.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22 1947 to May 22 1947 and that I last saw h[illegible] alive on May 22 1947

	DURATION
Immediate cause of death Cerebral hemorrhage	1 Day
Due to Hypertension	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. Lane M.D. M. D. or other

Address Frostburg Md Date signed 5-24-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A16

Within corporate limits

(W)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

CERTIFICATE OF DEATH

03553 4

Reg. Dist. No.

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. Mc Cool

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Kenneth Lambert

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1 1940

8. AGE: Years	Months	Days	If less than one day
7	3	16	hrs. min.

9. Birthplace: Franklin - Allegany Md (Town, county, and state)

10. Usual occupation: Student

11. Industry or business:

FATHER — 12. Name: Francis Lambert

13. Birthplace: Westernport Md

MOTHER — 14. Maiden name: Ethel L. Hedges

15. Birthplace: Franklin Md

16. Informant: Hospital Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 19, 1947 (month) (day) (year)

Cemetery or crematory (Bloomington) Md

Location: Bloomington Md

18. Funeral director: Edwards & Boal

Address: Westernport Md

19. May 18, 1947 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 1947 at 6:55 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19.. to 19..

and that I last saw h/M alive on DEAD May 17 1947

Immediate cause of death	DURATION
Meningitis	36 hrs.
Due to Skull fracture, Left side petrous portion of temporal bone	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 5-15-47

Where did injury occur? Westernport (City or town) Allegany (County) Md (State)

Injured at home, farm, industry, public place (where?) Westernport school grounds

Means of injury: Fell about 35 ft off [illegible] Injured at work? school

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H. V. Deming M.D. M. D. or other

Address: Cumberland Md Date signed 5-17-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I)

VS A15 9-45-15M (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 118

CERTIFICATE OF DEATH

03554

Reg. Diat. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Eckhart Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Eckhart, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Eckhart
(If outside city or town limits, write RURAL and give nearest town)

Street No. Parkersburg Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles Lancaster Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 4 1946

8. AGE: Years	Months	Days	If less than one day
0	9	17	..... hrs. ..... min.

9. Birthplace Eckhart, Md
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER 12. Name Charles Lancaster

13. Birthplace Eckhart Md.

MOTHER 14. Maiden name Mary Margaret Downton

15. Birthplace Zihlman Md.

16. Informant Parents

Address Eckhart Md.

17. Burial, Cremation, or removal. Which?) Burial Date thereof May 23rd., 1947
(month) (day) (year)

Cemetery or crematory Eckhart Cemetery

Location Eckhart, Md.

18. Funeral director Jacob Hafer

Address Frostburg, Md.

19. 5-22 1947 Mrs. Nancy N. Ada
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1947, at 10.10 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... im Dead May 21 1947

Immediate cause of death — DURATION

Spasm of the glottis — at once

Due to convulsions

Due to Vomiting heavy curds of milk & dentition

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. or other

Address Cumberland Md Date signed 5-21-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

03555 9

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 16 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R-2, No 1 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lena Loretta Leake

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Frank Leake

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Sept. 19th. 1886

8. AGE: Years: 60 Months: 8 Days: 2 If less than one day: ... hrs. ... min.

9. Birthplace: Vale Summit, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Michael Riggans

13. Birthplace: Mt. Savage, Md.

MOTHER 14. Maiden name: Mary [illegible] Delaney

15. Birthplace: New Jersey

16. Informant: Mr. Frank Leake

Address: R.D. No 1 Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-6-1947 (month) (day) (year)

Cemetery or crematory: St. Michaels

Location: Frostburg, Md.

18. Funeral director: Daniel Baker

Address: Frostburg Md

19. 5-5 1947 (Date rec'd by registrar) Mrs. Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 3 1947, at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 19.., to May 3 1947

and that I last saw h[illegible] alive on May 3 1947

Immediate cause of death	DURATION
Chronic Myocarditis	Several years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. D. McLane Jr. M.D. M. D. or other

Address: Frostburg Md. Date signed: 5-5-47

Within corporate limits

DR. C.L. OWENS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157e

CERTIFICATE OF DEATH

Reg. Dist. No. 5 05556

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 6 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town Near CUMBERLAND, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. RT. # 4
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME DONNA JOYCE LEASURE

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	INFANT

6.(b) Name of husband or wife —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) NOV. 22, 1946

8. AGE: Years	Months	Days	If less than one day
	5	27	hrs. min.

9. Birthplace CUMBERLAND, MD. (Town, county, and state)
10. Usual occupation INFANT
11. Industry or business

FATHER
12. Name LEONARD LEASURE
13. Birthplace OHIO

MOTHER
14. Maiden name JUANITA KIEFER
15. Birthplace OHIO

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 21, 1947 (month) (day) (year)
Cemetery or crematory Prosperity Church Cemetery
Location New Flintstone, Md.

18. Funeral director Lonis Stein Inc
Address Cumberland Md.

19. May 21, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 19 19 47, at 5:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18 19 47, to May 19 19 47
and that I last saw h alive on 19

	DURATION
Immediate cause of death	
Acute Lung Hemorrhage	1 day
Due to	
Pulmonary Congenital	12 Hours
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. L. Owens M.D. M. D. or other
Address Cumberland Md. Date signed 5-19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

DR. GRACIE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6 1 00

03557

Reg. Diat. No. 4

1. PLACE OF DEATH:

County ALLEGANY COUNTY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 4 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State PA Cooty SOMERSET

City or town SANDPATCH
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME ANNA LOTTIG

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Singie, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife John Lottig 6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) October 31, 1889

8. AGE: Years	Months	Days	If less than one day
57	6	4	hrs. min.

9. Birthplace Somerset Co. Pa.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER 12. Name WILSON CATON

13. Birthplace PA

MOTHER 14. Maiden name AGNES [redacted] Baer

15. Birthplace PA

16. Informant Donald Lottig

Address Sand Patch, Penna

17. Burial (Burial, cremation, or removal, Which?) Date thereof May 8, 1947 (month) (day) (year)

Cemetery or crematory White Oak

Location Sand Patch, Pa.

18. Funeral director H. P. Yonkers

Address Main St, Meyersdale, Pa

19. May 5 1947 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 5, 1947 at 11:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1947 to May 5 1947

and that I last saw her alive on May 5 1947

Immediate cause of death	DURATION
(a) Coma - Diabetes	
Due to (b) Operation - Gangrenous gall bladder	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Gangrenous gall bladder Date of op. May 3-47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. A. Gracie M. D. or other

Address Cumberland Date signed 5-5-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

DR. JACOBSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

03558 4

Reg. Dist. No.

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 825 SHRIVER AVE.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MR. JOHN E. MAREAN

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife MATILDA BLAUL
6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) JAN. 26, 1888

8. AGE: Years	Months	Days	If less than one day
59			hrs. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual occupation ASST. CITY ENGINEER
11. Industry or business

FATHER
12. Name ALBERT E. MAREAN
13. Birthplace PENNSYLVANIA

MOTHER
14. Maiden name CATHERINE L. RANK
15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 10, 1947 (month) (day) (year)
Cemetery or crematory Rolling Green
Location Cumberland, Md.
18. Funeral director Louis Stein, Inc.
Address Cumberland, Md.

19. May 8, 1947 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 7 1947, at 11:26 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28 1947, to May 7 1947
and that I last saw h[illegible] alive on May 7 1947

Immediate cause of death	DURATION
Myocardial Failure	1 week
Due to Acute Anterior Myocardial Infarction	9 days
Due to Coronary Artery Disease	?
Other conditions Uremia	3 days

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address [illegible] Date signed 5/8/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

Dr. Schindler

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

03559

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 604 Elm Street

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME David Metheny

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 24 May 1947

8. AGE:

Years	Months	Days	If less than one day
—	—	—	½ hrs. ..... min.

9. Birthplace Cumberland Allegany Maryland

(Town, county, and state)

10. Usual occupation none

11. Industry or business —

FATHER

12. Name David Metheny

13. Birthplace Kingwood, West Va.

MOTHER

14. Maiden name Wanda Zembower

15. Birthplace Maryland

16. Informant Miss Joyce Zembower

Address 314 Emily St. Cumberland Md

17. buried (Burial, cremation, or removal. Which?) Date thereof May 26 1947 (month) (day) (year)

Cemetery or crematory River Hill Cemetery

Location Cumberland Md.

18. Funeral director Louis Stein Inc.

Address Cumberland Md.

19. May 26, 19 47 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24, 1947, at 5:55 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Prematurity	6 Hrs 7 Min. Duration
Due to Hypertension C.V.D. Pneumothorax	4 Months
Due to	
Other conditions Pregnancy	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE B. M. Schindler M.D. M. D. or other

Address 41 Greene St. Cumberland Md. Date signed May 26 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

DR. FAW

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

170c

Reg. Dist. No. 03560

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? FIVE HOURS
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? FIVE HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: WEST VIRGINIA County: HAMPSHIRE
City or town: ROMNEY
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: GLENNA MAYHEW

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife:
6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): Feb. 28, 1928

8. AGE: Years	Months	Days	If less than one day
19	2	13	... hrs. ... min.

9. Birthplace: W. VA., Hampshire County (Town, county, and state)
10. Usual occupation: STUDENT
11. Industry or business:

FATHER
12. Name: MAYHEW, WILLIAM
13. Birthplace: WEST VIRGINIA

MOTHER
14. Maiden name: PRISCILLA BARNES
15. Birthplace: WEST VIRGINIA

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 13, 1947 (month) (day) (year)
Cemetery or crematory: Baptist Cem
Location: Three Churches W. Va.
18. Funeral director: Hilt Mckee
Address: Augusta W. Va.

19. May 12, 1947 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 11, 1947, at 9:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAY 11, 1947, to MAY 11, 1947 and that I last saw her alive on May 11, 1947

Immediate cause of death	DURATION
Retro-Peritoneal hemorrhage	7 hrs
Due to: concealed.	
Due to: Multiple fractures of pelvis	
Other conditions: Auto. accident 1.40 A.M. 5-11-47	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 5-11-47
Where did injury occur? near Romney W. Va. Route 28 Hampshire (City or town) (County) W. Va. (State)
Injured at home, farm, industry, public place (where?): Route 28
Means of injury: Auto Accident Injured at work?

23. SIGNATURE: W. C. Romney M.D. Wyles Faw J. M. D. M. D. or other
Address: Cumberland Md Date signed: 5-12-47

Within corporate limits

DAK ENTFELD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46d dB

CERTIFICATE OF DEATH

03561 4
Reg. Dist. No.

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
MEMORIAL Hospital
How long in hospital or institution? 10 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State WEST VA. County Morgan
City or town PAW PAW
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME LESTER McCAULEY

3.(b) Social Security Number 237-10-2550

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 3, 1894

8. AGE: Years 52 | Months 7 | Days 9 | If less than one day hrs. min.

9. Birthplace W.VA.
(Town, county, and state)

10. Usual occupation TANNERY

11. Industry or business

FATHER
12. Name GEORGE McCAULEY
13. Birthplace W. A.

MOTHER
14. Maiden name LENA FRAVEL
15. Birthplace W.VA.

16. Informant Victor Mc Cauley.
Address Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/14/47 (month) (day) (year)
Cemetery or crematory Camp Hill
Location Paw Paw W.Va.

18. Funeral director Davis Stein Inc.
Address 117 Frederick St Cumb. Md.

19. May 13 1947 (Date rec'd by registrar) J. L. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 12 1947 at 8:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1947 to May 12 1947 and that I last saw h alive on May 11 1947

Immediate cause of death Coronary Occlusion

DURATION

Due to Carcinoma ? Pulmonary

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation Carcinoma of Pulmonary Artery + Thrombus globus Date of op May 5 47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. L. Franklin M.D.
M. D. or other
Address Cumberland Date signed 5/12/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

74a

03562

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years

Hospital, institution, or street address where death occurred:
120 Wilmont Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 120 Wilmont Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John William McClure, III

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 18, 1938

8. AGE:

Years	Months	Days	If less than one day
9	3	22	hrs. min.

9. Birthplace Memphis, Tenn
(Town, county, and state)

10. Usual occupation Child

11. Industry or business School

FATHER 12. Name John William McClure, Jr.

FATHER 13. Birthplace Memphis, Tenn

MOTHER 14. Maiden name Charlotte V. Bowie

MOTHER 15. Birthplace Cumberland, Md.

16. Informant Gordon Bowie

Address Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 12, 1947 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hofer

Address Cumberland, Md.

19. May 12, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1947, at 11:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to May 10 1947

and that I last saw h[illegible] alive on May 1 1947

Immediate cause of death Myloid Leukemia — DURATION 16 Mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Myloid Leukemia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Franklin M. D. or other

Address 126 Greene St Cumberland Md Date signed 5/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

03563

Reg. Diat. No. 6

1. PLACE OF DEATH:

County Allegany

City or town Barton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Barton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lawrence McConnell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Nickel McConnell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1876

8. AGE:

Years	Months	Days	If less than one day
70	6	22	..... hrs. ..... min.

9. Birthplace Barton Allegany Md.

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER

12. Name James C. McConnell

13. Birthplace Moscow, Md.

MOTHER

14. Maiden name Anna L. Howalter

15. Birthplace Fairmont, W. Va.

16. Informant William McConnell

Address Barton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 25 1947 (month) (day) (year)

Cemetery or crematory Laurel Hill

Location Moscow, Md.

18. Funeral director Ellsworth S. Boal

Address Westernport, Md.

19. May 25 1947 Ellsworth S. Boal M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1947, at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive on May 23 1947

Immediate cause of death	DURATION
Chronic myocarditis	Several years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. M. D. or other

Address Cumberland Md. Date signed 5-23-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

DR. JACOBSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03564

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State MARYLAND County GARRETT
City or town ACCIDENT (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME MILLER, DELLA MRS

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife MILLER, JOHN
6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) october 15, 1887

8. AGE:	Years	Months	Days	If less than one day
	59	7	0	hrs. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name FRIEND, JESSE
13. Birthplace MARYLAND

MOTHER
14. Maiden name GRAY, MARY
15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-18-1947 (month) (day) (year)
Cemetery or crematory accident Cem.
Location accident, Md.

18. Funeral director Allen Whitenberg
Address grantsville Md

19. May 18, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 15, 1947, at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14 1947 to May 15 1947 and that I last saw her alive on May 14 1947

Immediate cause of death	DURATION
Cerebrovascular Accident (Embolism)	1 day
Due to Paralysis Appendicitis	1 day
Due to Myocardial Fibrosis	?
Coronary Artery Sclerosis	?
Other conditions Diabetes Mellitus	?

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Ronald Jacobson M. D. or other
Address Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95

CERTIFICATE OF DEATH

Reg. Dist. No. 03565

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Rural) R.F.D.3 Keyser W.Va.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town rural) R.F.D.3 Keyser W.Va.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Black Oak Bottom Farm
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Joseph Miller

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 5 1919

8. AGE: Years	Months	Days	If less than one day
28	1	14	..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Robert L. Miller
13. Birthplace Kline W.Va

MOTHER
14. Maiden name Minnie A.Heavner
15. Birthplace Kline W.Va.

16. Informant Robert L.Miller

Address Rural) R.F.D 3 Keyser W.Va.

17. burial Date thereof May 17, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Black Oak Bottom Farm

Location rural) Allegany Co.Md.

18. Funeral director N.L. Rogers Funeral Service

Address Keyser W.Va.

19. 5/16/47 (Date rec'd by registrar) M.W. Thomas Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 19 47 at 12 a.m. 50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive on May 15 19 47

Immediate cause of death	DURATION
Strangulation	at once
Due to Epileptic convulsion G.M.	
Due to	
Other conditions Epileptic for 14 years	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. or other

Address Cumberland Md. Date signed 5-15-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03566

159

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 67 Mt Pleasant St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Margaret Louise Myers

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 10, 1947

8. AGE: Years | Months | Days: 0 | If less than one day: 15 hrs. min.

9. Birthplace: Frostburg Md
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Lester Herbert Myers
13. Birthplace: Somerset Pa

MOTHER
14. Maiden name: Mary Margaret Kelly
15. Birthplace: Frostburg Md

16. Informant: Mrs Lester Myers
Address: Frostburg

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-11-47 (month) (day) (year)
Cemetery or crematory: St. Michaels Cemetery
Location: Frostburg, Md.

18. Funeral director: Jacob Hafer
Address: Frostburg, Md.

19. 5-11 1947 Mrs Nancy N. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11 1947, at 7:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1947, to May 11 1947
and that I last saw h alive on May 11 1947

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Hilda Jane Watkins MD
M. D. or other
Address: Frostburg Date signed 5/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 139a

Dr. J. T. Johnson

03567

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town R.D. 1 La Vale Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Stella Nixon

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife Virgil Nixon

6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) February 19, 1893

8. AGE: Years	Months	Days	If less than one day
54	3	9	hrs. min.

9. Birthplace Frostburg Allegany Cty., Md. (Town, County, and State)

10. Usual occupation housewife

11. Industry or business home

FATHER 12. Name Charles Chidester,

FATHER 13. Birthplace West Virginia.

MOTHER 14. Maiden name Sarah Williams

MOTHER 15. Birthplace Maryland

16. Informant Virgil Nixon

Address La Vale, Cumberland Md.

17. Burial, (Burial, cremation, or removal. Which?) Date thereof May 31, 1947 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg Md.

18. Funeral director J. R. Hurst

Address Frostburg Md.

19. May 29, 1947 (Date rec'd by registrar) J. C. Frankhi, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1947, at 5A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 1947 to May 28 1947

and that I last saw [illegible] alive on May 25, 1947

Immediate cause of death Sepsis — DURATION 5 days

Due to Acute Gangrenous dermoid cyst of ovary — 4 days

Due to

Other conditions Myocarditis Ulcers Bilateral dermoid cysts of ovary

(Include pregnancy within 3 months of death)

Major findings of operation Acute gangrenous dermoid cyst of ovary and tube — Date of op. 5-24-47

Autopsy (yes or no)? Results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. T. Johnson Jr. M.D. M. D. or other

Address Cumberland Md. Date signed 5-29-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

147d

03568

Reg. Diat. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg [illegible] Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? One day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 11 Bowery St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Theresa Agness Perry

3.(b) Social Security Number: 217-10-4433

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Married

6.(b) Name of husband or wife: Frank Perry

6.(c) If alive, give age: 24 years

7. Birth date of deceased (mo., day, yr.): Mar. 20, 1914

8. AGE:

Years	Months	Days	If less than one day
33	1	25	..... hrs. ..... min.

9. Birthplace: Frostburg Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Joseph Cocella

FATHER 13. Birthplace: Italy

MOTHER 14. Maiden name: Jennie Mascio

MOTHER 15. Birthplace: Italy

16. Informant: Frank Perry

Address: Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 16, 1947 (month) (day) (year)

Cemetery ~~or crematory~~: St. Michaels

Location: Frostburg Md

18. Funeral director: Jacob Hafer

Address: Frostburg Md.

19. 5-15 (Date rec'd by registrar) 1947 Mrs. Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14, 1947 at 4 05 ESI A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1946 to 5-14 1947

and that I last saw her alive on 5-14 1947

Immediate cause of death	DURATION
Pulmonary Embolus	20min
Due to: Parturition	
Due to:	
Other conditions: Delivered of living child 11 25 PM EST 5/13/47 (Include pregnancy within 3 months of death)	

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Hilda Laurel Atty M.D. M. D. or other

Address: Frostburg Md Date signed: 5/14/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

03569

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 59 Years

Hospital, institution, or street address where death occurred:
230 Bond St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 230 Bond St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Emma E. Poole

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife: John Poole

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): February 25 1878

8. AGE: Years	Months	Days	If less than one day
69	3	0	...hrs. ...min.

9. Birthplace: Hancock, Washington Co, Maryland
(Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER
12. Name: William Poole
13. Birthplace: Hancock, Md.

MOTHER
14. Maiden name: Mariah Oakman
15. Birthplace: Buck Valley, Pa.

16. Informant: Mrs Harriett Lannon

Address: 230 Bond St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/27/47 (month) (day) (year)

Cemetery or crematory: Fairview Cemetery

Location: Inglesmith, Pa.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. May 27 1947 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 19 47, at 6.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw her alive on May 25 19 47
Dead

Immediate cause of death	DURATION
Diabetes Mellitus	about 1 year
Due to	
Due to	
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work? Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H. V. Deming M.D. H V Deming M.D.
M. D. or other

Address: Cumberland Md. Date signed: 5-25-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

03570

CERTIFICATE OF DEATH

Reg. Diat. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 years

Hospital, Institution, or street address where death occurred:

67 Frost Ave.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 67 Frost Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Owen Loyola Foster

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Anna Jones

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31 - 1872

8. AGE:

Years	Months	Days	If less than one day
75	11	17	hrs. min.

9. Birthplace Frostburg, Alleg. Md.

(Town, county, and state)

10. Usual occupation Judge

11. Industry or business Ex Magistrate

FATHER 12. Name Thos. Foster

13. Birthplace Frostburg, Md.

MOTHER 14. Maiden name Mary O'Connor

15. Birthplace Boston, Mass.

16. Informant Jas. Cosgrove

Address 67 Frost Ave. Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-22-1947 (month) (day) (year)

Cemetery or crematory St. Michaels Cem.

Location Frostburg, Md.

18. Funeral director Jacob Kaufman

Address Frostburg, Md.

19. 5-20 1947 Miss. Nancy N. Bell Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1947 at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1947 to May 19 1947

and that I last saw him alive on May 18 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 Day
Due to Arterio Sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Wm. McLane M.D. M. D. or other

Address Frostburg Md Date signed 5-19-47

Wm McLane

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03571

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, Institution, or street address where death occurred: Allegany Hospital

How long in hospital or Institution? 12 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Mt. Savage (If outside city or town limits, write RURAL and give nearest town)

Street No.: Main St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Angela Reagan

3. (b) Social Security Number: none

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Joseph Reagan

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): November 17, 1904

8. AGE: Years: 42 Months: 6 Days: 2 If less than one day: hrs. min.

9. Birthplace: Ocean Allegany Co. Md. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: home

FATHER 12. Name: Patrick Dugan

13. Birthplace: Ireland

MOTHER 14. Maiden name: Annie McGuire

15. Birthplace: unknown

16. Informant: Joseph Reagan

Address: Mt. Savage Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: May 23 1947 (month) (day) (year)

Cemetery or crematory: St. Patrick's Cemetery

Location: Mt. Savage Md.

18. Funeral director: J. R. Duffy

Address: Frostburg Md.

19. May 21, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/20/47 19... at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/14/47 19... to 5/20/47 19...

and that I last saw h.e alive on 5/19/47 19...

Immediate cause of death	DURATION
Pneumonia, embolism	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: acute cholecystitis

Date of op. 5/ /47

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)...

Means of injury... Injured at work?

23. SIGNATURE: John N. Rozzell M. D. or other

Address: Cumberland Md. Date signed: 5/21/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

Dr. Durrett

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03572

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 years

Hospital, Institution, or street address where death occurred:
62 Marion St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 62 Marion St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charity Isabel Reckley

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Paul Reckley

6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): August 16, 1908

8. AGE: Years	Months	Days	If less than one day
38	9	0	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER
12. Name: Joseph D. Boden
13. Birthplace: Piney Grove, Md.

MOTHER
14. Maiden name: Julia A. Hartley
15. Birthplace: Oldtown, Md.

16. Informant: Paul Reckley
Address: 62 Marion St., Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 19 1947 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hahn

Address: Cumberland, Md.

19. May 19, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16, 1947, at 9:05 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 12, 1947, to May 16, 1947, and that I last saw her alive on May 15, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis ?	
Bilateral	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Cumberland Date signed: 6/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

Dr Diehl 03573

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:
County Allegany
City or town Eckhart
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all her life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Eckhart
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Martha Elizabeth Rephann

3.(b) Social Security Number none

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Joseph Rephann
6.(c) If alive, give age: 72 years
7. Birth date of deceased (mo., day, yr.): January 29, 1881
8. AGE: Years 66 Months 3 Days 11 If less than one day ... hrs. ... min.
9. Birthplace: Eckhart Allegany, Md. (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business: home
FATHER 12. Name: unknown
13. Birthplace: "
MOTHER 14. Maiden name: unknown
15. Birthplace: "
16. Informant: Mrs. Dorothy Mac Gregor
Address: Eckhart Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 14 1947 (month) (day) (year)
Cemetery or crematory: Eckhart Cemetery
Location: Eckhart Md.
18. Funeral director: J. R. Durst
Address: Frostburg Md.
19. 5-13 1947 (Date rec'd by registrar) Mrs. Hattie N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11 1947, at 4 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 6 1945, to May 11 1947 and that I last saw h... alive on May 11 1947
Immediate cause of death: Hypertension cardio-vascular renal disease — DURATION: 5 yrs.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: X
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: X Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. C. Diehl, M.D. M. D. or other
Address Frostburg, Md. Date signed 5/13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits Louis Bringo

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

03574

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, Institution, or street address where death occurred:

146 Wineow St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 146 Wineow St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Eleanor "Johnson" Rhodes

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negress	Married

6.(b) Name of husband or wife Wm. Henry Rhodes

6.(c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) April 8 - 1877

8. AGE: Years	Months	Days	If less than one day
70	—	28	hrs. min.

9. Birthplace Cumberland Allegany Co. Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER 12. Name Wilson Johnson

13. Birthplace Virginia

MOTHER 14. Maiden name Ellen Jane Abel

15. Birthplace Virginia

16. Informant Mary Jane Rhodes

Address 146 Wineow St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 17, 1947 (month) (day) (year)

Cemetery or crematory Sts. Peter & Paul's Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hoke

Address Cumberland Md.

19. May 10 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1947, at 9:50 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12 1947 to May 6 1947

and that I last saw h.. alive on May 5 1947

	DURATION
Immediate cause of death Congestive heart failure	4 Months
Due to Chronic myocarditis	7 Yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. H. Kline M.D. M. D. or other

Address 59 Greene St. Date signed 5-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

03575

CERTIFICATE OF DEATH

Reg. Diat. No. 2

1. PLACE OF DEATH:

County: Allegany

City or town: Flintstone

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 Years

Hospital, institution, or street address where death occurred:

Flintstone Rt. 1.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Flintstone

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rt. 1.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Homer C. Rice

3.(b) Social Security Number: 216-22-6909

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Zerna Jordan Rice

6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): April 24 1898

8. AGE: Years	Months	Days	If less than one day
49	0	9	hrs. min.

9. Birthplace: Cumberland, Allegany Co, Maryland (Town, county, and state)

10. Usual occupation: Boiler House

11. Industry or business: Celenese Corporation

FATHER

12. Name: Moses A. Rice

13. Birthplace: B edford Valley, Pa

MOTHER

14. Maiden name: Margaret Dicken

15. Birthplace: Bedford Valley, Pa.

16. Informant: Mrs. Homer C. Rice

Address: Rt, 1. Flintstone, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/6/47 (month) (day) (year)

Cemetery or crematory: Zion Memorial Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. May 6 (Date rec'd by registrar) 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 3 1947, at 11-15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/24 1947, to May 3 1947 and that I last saw h[illegible] alive on April 14 1947

Immediate cause of death	DURATION
Uremia	?
Due to: Congestive Polycystic Kidneys Bilateral	?
Due to: Hypertensive Cardio-Vascular Renal Dis	?
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: [illegible] Date signed: 5/8/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

186a

03576 2

Reg. Dist. No.

1. PLACE OF DEATH:

County: Allegany

City or town: Flintstone

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 Years

Hospital, institution, or street address where death occurred: Residence Flintstone R#2

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Flintstone

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R#2.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Elizabeth Robosson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Charles T. Robosson, Sr.

6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): June 30 1870

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
76	10	6		

9. Birthplace: Grantown Strath Spey, Scotland. (Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER — 12. Name: George M. Smith

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Margaret McClean

MOTHER — 15. Birthplace: Scotland

16. Informant: Charles T. Robosson, Sr.

Address: Flintstone, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/9/47 (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. May 8 18 47 (Date rec'd by registrar) Nina L. Bender Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6 19 47 at 8-25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25 19 47 to May 6 19 47

and that I last saw h... alive on May 1st 19 47

Immediate cause of death	DURATION
Accidental trauma	
due to a fall	12 days
Due to	
Due to	
Other conditions: Chronic myocarditis	6 mos.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. N. Trenaskis, Jr. M.D. M. D. or other

Address: Cumberland, md Date signed: 5/8/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

M

Frank Wilson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

03577

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County Allegany
City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 1003 Kentucky Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Allegany
City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)
Street No. 1003 Kentucky Ave. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs Elizabeth Ann Seaders

3.(b) Social Security Number None

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife John Seaders
6.(c) If alive, give age 72 years
7. Birth date of deceased (mo., day, yr.) Dec 13 1863

8. AGE: Years 83 Months 5 Days 5 If less than one day ... hrs. ... min.

9. Birthplace Cresaptown Allegany Co Md (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Enoch McKenzie
13. Birthplace Cresaptown Md
MOTHER 14. Maiden name Mary Adkins
15. Birthplace Cumberland Md
16. Informant Rosalia Seaders
Address Cumberland Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 21, 1947 (month) (day) (year)
Cemetery or crematory St Mary's Cemetery
Location Cumberland, Md.
18. Funeral director John J. Hafer
Address Cumberland
19. May 21, 1947 (Date rec'd by registrar) J. P. Laukhin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1947 at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw her alive on ... 19...

Immediate cause of death: Coronary Thrombosis — DURATION ?

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

F. H. Wilson Ind

23. SIGNATURE Samuel Jacobson M.D.
Address [illegible] Date signed 5/21/47

Within corporate limits

DR. DURRETT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

03578

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: MARYLAND County: ALLWGANY

City or town: CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

Street No.: 536 MARYLAND AVE. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: MRS. AGNes SHEA

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: MICHAEL SHEA

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): MAY 14 1876

8. AGE: Years: 70 Months: 11 Days: 20 If less than one day: hrs. min.

9. Birthplace: MARYLAND (Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business:

FATHER — 12. Name: THOMAS MORRIS

FATHER — 13. Birthplace: DISTRICT OF COLUMBIA

MOTHER — 14. Maiden name: CHRISTINA NELSON

MOTHER — 15. Birthplace: SCOTLAND

16. Informant: Mr. William Shea

Address: 607 Shriver Ave. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 6, 1947 (month) (day) (year)

Cemetery or crematory: St. Michaels Cem.

Location: Frostburg, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. May 5 19 47 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 4, 1947 4;05 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 1. 1947 to Mar. 4. 1947 and that I last saw her alive on Mar. 3. 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Left Hemiplegia	3 days
Due to: Uraemia	3 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Clay R Lewis M. D. or other

Address: Cumberland Date signed: 5-15-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

03579

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 Years

Hospital, Institution, or street address where death occurred:
226 South Lee St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 226 South Lee St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Elizabeth Smith

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife: Charles Smith

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 6 1870

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
77	1	4		

9. Birthplace: Rippon, W.Va Jefferson Co.
(Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER
12. Name: Issac Johnson
13. Birthplace: Rippon, W. Va.

MOTHER
14. Maiden name: Lucinda Johnson
15. Birthplace: Rippon, W. Va.

16. Informant: Mrs Lina Yates

Address: 226 South Lee St, Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/13/47 (month) (day) (year)

Cemetery or crematory: Rippon Cemetery

Location: Rippon, W. Va.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. May 12, 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10 1947, at 2-15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 1947 to May 10 1947 and that I last saw h... alive on May 9 1947

Immediate cause of death	DURATION
Cerebral Embolism	2 days
Due to: Hypertension C.V.D. Uremia	years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: B. M. Schneider M.D.
M. D. or other

Address: 4 Greene St. Cumberland, Md. Date signed: May 10 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Wiseman

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46 2

CERTIFICATE OF DEATH

03580 Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Rt 3, Keyser, W.Va.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 Years

Hospital, Institution, or street address where death occurred:
Rt. 3 Keyser, W.Va.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Rural (Rawlings)
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt. 3, Keyser, W.Va.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ray Ramsey Smith

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Susanna Twigg Smith

6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) November 13, 1882

8. AGE:

Years	Months	Days	If less than one day
64	5	28	...hrs. ...min.

9. Birthplace Clarksburg, W.Va.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Engineer for hotel company

FATHER 12. Name James Smith

FATHER 13. Birthplace Virginia

MOTHER 14. Maiden name Martha Arnold

MOTHER 15. Birthplace Clarksburg, W.Va.

16. Informant Mrs. Susanna Smith

Address Rt. 3, Keyser, W.Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 13, 1947 (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md.

18. Funeral director John F. Hoffman

Address Cumberland, Md.

19. May 13, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 1947, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946, to May 11, 1947

and that I last saw h.. L.M. alive on May 11, 1947

	DURATION
Immediate cause of death SHOCK DUE TO PERFORATION OF NEOPLASM OF COLON	12 hours
Due to Partial intestinal obstruction with a mass felt on rectal exam.	3 months
Due to Believe it was a neoplasm, probably malignant of the first part of the large bowel [Mac/4 abc]	March
Other conditions ARTHRITIS, SEVERE, RHEUMATOID	20 years

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury Injured at work?

23. SIGNATURE A G Wiseman MD
M. D. or other

Address Cresaptown, Md Date signed 5/13/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95C

CERTIFICATE OF DEATH

03581

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 yrs, 10 mos, 29 days

Hospital, institution, or street address where death occurred:
113 Polk Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 113 Polk St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Andrew Sullivan

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 9, 1915

8. AGE: Years	Months	Days	If less than one day
31	10	29	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany County, Maryland
(Town, county, and state)

10. Usual occupation: Invalid

11. Industry or business

FATHER
12. Name: Andrew Sullivan
13. Birthplace: Pekin, Maryland

MOTHER
14. Maiden name: Loretta Cavan
15. Birthplace: Pekin, Maryland

16. Informant: Alexander F. Schute
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 10, 1947 (month) (day) (year)

Cemetery or crematory: St. Patrick's Cem.

Location: Cumberland, Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md.

19. May 8, 1947 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8, 1947, at 1.40A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2, 1947, to May 8, 1947

and that I last saw him alive on May 7, 1947

Immediate cause of death	DURATION
Acute dilatation of the heart	at once
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

~~Deputy Medical Examiner Allegany Co.~~

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D. M. D. or other

Address Cumberland Md. Date signed 5-8-47

Within corporate limits

DR. GROVE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46c

03582

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
MEMORIAL, CUMBERLAND, MD.

How long in hospital or institution? 5 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town ~~EXMEWESTERNPORT~~
(If outside city or town limits, write RURAL and give nearest town)

Street No. 118 PHILLIS AVE.,
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME JAMES TONRY

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife KATTIE BICE

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) SEPT. 5, 1857

8. AGE: Years	Months	Days	If less than one day
89			..... hrs. ..... min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation Retired Carpenter

11. Industry or business

FATHER
12. Name JAMES TONRY
13. Birthplace IRELAND

MOTHER
14. Maiden name REBECCA BROADWATER
15. Birthplace MARYLAND

16. Informant Mrs. Jas. Tonry
Address W Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 23 1947 (month) (day) (year)

Cemetery or crematory Philos

Location W Cumberland Md

18. Funeral director W. Hubert Feddock Jr.

Address Piedmont W. Va.

19. May 20 1947 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 20 1947 at 10:35A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15, 1947, to May 20, 1947 and that I last saw him alive on May 20 1947

Immediate cause of death Arteriosclerosis gangrene L Lft leg — DURATION 1 wk.

Due to Carcinoma Reginae Colon.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Carcinoma Reginae Colon

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. B. Moore M.D.
M. D. or other

Address Medical Bldg Cumberland, Date signed 5-20-47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

03583

Reg. Dist. No. 4

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Allegany

City or town Rural Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. R 5 — Inc Mullers Hwy

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Mary Barton Vocke

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Harmon A Vocke

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 16 1876

8. AGE: Years	Months	Days	If less than one day
70	7	15	..... hrs. ..... min.

9. Birthplace Cumberland Md

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER

12. Name John Barton

13. Birthplace Ireland

MOTHER

14. Maiden name Anna Devore

15. Birthplace Maryland

16. Informant John F Vocke

Address 603 Johnson Ave Cumb'd Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/5/47 (month) (day) (year)

Cemetery or crematory St Ambrose

Location Creasaptown Md.

18. Funeral director Lantz Stein Inc.

Address Cumberland Md.

19. May 3 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1947, at 10 12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 1947 to May 1 1947

and that I last saw h.. alive on May 1 1947

Immediate cause of death	DURATION
congestive heart failure	6 week
Due to chronic myocarditis	6 months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE (Illegible) M.D. M. D. or other

Address 59 Greene St. Date signed 5-2-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

03584

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 93 yrs

Hospital, Institution, or street address where death occurred 103 Greene St.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 103 Greene St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Thomas Webster

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Mary Ann Jones

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 28 1854

8. AGE: Years	Months	Days	If less than one day
93	2	12	..... hrs. ..... min.

9. Birthplace Cumberland Md (Town, county, and state)

10. Usual occupation Home. Retired 20 yrs.

11. Industry or business

FATHER 12. Name Thomas Webster

13. Birthplace Md.

MOTHER 14. Maiden name Elizabeth Holmes

15. Birthplace Md

16. Informant James Webster

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 13 47 (month) (day) (year)

Cemetery or crematory St. Peter & Paul's Cem.

Location Cumberland

18. Funeral director Louis Stein Sons

Address Cumberland

19. May 12 1947 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 19 47 at 4 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 47 to May 10 19 47 and that I last saw h alive on May 8 19 47

Immediate cause of death Generalized arteriosclerosis DURATION 5 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. J. Johnson Jr. M.D. M.D. or other

Address Cumberland Md Date signed 5-13-47

Within corporate limits [redacted]

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

170c CB

Reg. Dist. No. 03585

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution? about 16 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W. VA. County GRANT
City or town PETERSBURG
(If outside city or town limits, write RURAL and give nearest town)
Street No. Myrtle Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MR. EMMETT W. [redacted] Whitesel

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
68			hrs. min.

9. Birthplace VA.
(Town, county, and state)

10. Usual occupation FEDERAL LAND BANK BALTIMORE

11. Industry or business MD.

FATHER
12. Name JAMES [redacted] Whitesel
13. Birthplace VA.

MOTHER
14. Maiden name ALICE AMELIA HARMAN
15. Birthplace W.VA.

16. Informant Memorial Hospital
Address Cumberland, Md.

17. Burial Date thereof May 17 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Harmon Cem
Location Near Petersburg, W. Va.

18. Funeral director P. E. Wenzel
Address Mountain View

19. May 15 1947 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 4;55 A.M.

20. DATE OF DEATH MAY 15, 1947 19 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 to 19
and that I last saw h. l. m. Dead May 15 1947

Immediate cause of death — DURATION
S. Thrombosis Pulmonary Embolism — about
also Cerebral completion — 2.0 hrs
Due to Cerebral Congestion
Due to Automobile accident 5/14/47
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 5-14-47
Where did injury occur? Route 220 near Petersburg (City or town) Grant (County) W. Va. (State)
Injured at home, farm, industry, public place (where?) on above
Means of injury Auto collision Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D.
M. D. or other
Address Cumberland Md. Date signed 5-15-47

Within corporate limits ?

Call 2 ?

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 70 Orchard St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Richard Wiegand

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Hermina Schultz

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 24 1873

8. AGE:

Years	Months	Days	If less than one day
74	3	15	..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: mattress manufacturer

11. Industry or business: Owner - Mattress Factory

FATHER 12. Name: Unknown

13. Birthplace

MOTHER 14. Maiden name: Unknown.

15. Birthplace

16. Informant: Wm Wiegand

Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 12 '47 (month) (day) (year)

Cemetery or crematory: Greenmount Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. May 17 19 47 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 19 47, at 9 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/21/47 19 to 5/9 19 47

and that I last saw h[illegible] alive on 5/9/47 19

Immediate cause of death	DURATION
Gangrene of foot.	
Due to arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Gangrene of foot Date of op. 5/6/47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John K. Lozier M D M. D. or other

Address: Cumberland Md Date signed: 5/11/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

03587

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, Institution, or street address where death occurred:
Allegany County Home
How long in hospital or institution? 3 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Barton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Otto Winkler

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 72 | Months | Days | If less than one day hrs. min.

9. Birthplace [redacted] Barton Alleg Co., Md (Town, county, and state)

10. Usual occupation miner - Retired

11. Industry or business Coal Mine

FATHER 12. Name [redacted] George Winkler

13. Birthplace Unknown

MOTHER 14. Maiden name [redacted] Madeline Rohing

15. Birthplace Unknown

16. Informant Hospital Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 30, 1947 (month) (day) (year)

Cemetery or crematory St. Gabriels Cemetery

Location Barton, Md

16. Funeral director E. S. Boal

Address Westernport Md.

19. May 27 1947 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1947 at 3:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 3 1946, to May 27 1947

and that I last saw him alive on May 27 1947

Immediate cause of death	DURATION
Myocardial failure	24 hrs.
Due to Chronic Myocarditis	3 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur F. Jones M.D.
M. D. or other

Address 110 S. Centre St. Date signed 5-27-47

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING